EDS Adjustments Unit

Adjustments Operating Procedures Manual

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INDIANA HEALTH COVERAGE PROGRAMS

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Section 1: Introduction

Overview

This manual describes the functional aspects of the adjustments system in Indiana*AIM*. It provides a detailed description of how EDS processes claim-specific adjustments and nonclaim-specific financial transactions received from providers and other internal or external entities, such as Indiana Family and Social Services Administration (IFSSA), lien holders, the Customer Assistance Unit, or the long term care (LTC) rate-setting contractor. It is designed as a procedural reference about the various functions in the Adjustments Unit, and is used to train new employees.

The Adjustments Unit's responsibility is to process all claim-specific adjustment transactions and nonclaim-specific financial transactions in a timely manner. Each person in the unit is fully trained to perform the assigned responsibilities.

Goals and Objectives

The Adjustments Unit is committed to providing excellent service to meet the needs of the state of Indiana in all aspects of adjustment transaction processing. This is accomplished in the following steps:

- Maintain full contract compliance
- Retain a qualified, highly-trained staff to assume the various responsibilities and perform daily tasks
- Ensure compliance with all federal regulations and State statutes applicable to the Adjustments Unit
- Create an environment that promotes continuous process improvement
- Ensure accuracy and timeliness of all adjustment processing and responses
- Maintain a strong relationship with the customer through continuous open communication

Section 2: Department Organization and Staffing

Introduction

The Adjustments Unit is under the guidance of the claims manager and consists of one full-time supervisor and six full-time staff members. The responsibilities of the positions are listed in the subsections that follow.

Claims Manager

- Oversees daily operation of the Adjustments Unit
- Serves as liaison with the Office of Medicaid Policy and Planning (OMPP)
- Oversees unit performance related to contract compliance
- Provides strategic enhancement of the adjustments transaction process
- Provides leadership and direction

Adjustments Supervisor

- Directs daily production and work flow of the unit
- Monitors unit performance related to contract compliance
- Manages the adjustment transaction process
- Develops and maintains all adjustment operating procedure manuals
- Performs tasks related to personnel administration

Adjustments Team Leader

- Monitors *FIN-1004-D*, *CLM-0185-D*, and *FIN-1008-D* reports
- Performs quality checks
- Research and process special adjustment requests received via e-mail from the supervisor or other departments
- Monitors the signing in and out of staff members
- Writes and submits local area network (LAN) and Indiana*AIM* ID requests
- Submits weekly production and quality reports to the supervisor
- Ensures that all expenditures and accounts receivables are completed and logged
- Ensures that all mass and reprocessing adjustments are completed in a timely manner
- Ensures that all retroactive rate adjustments are activated in a timely manner and that all suspense related to retroactive rate adjustments are worked in a timely manner

Section 3: Adjustments Work Flow Procedures

Introduction

This section describes procedures and workflow for claim-specific adjustments. An adjustment is defined as a request to change historical data or reimbursement for a claim. Adjustments are classified in two categories: check-related (refund), or noncheck-related, and further categorized as either full or partial. Claim adjustment types are described in the sub-sections.

Check-related Adjustment

Full Claim Refund

This adjustment occurs when the provider or EDS recognizes that a claim should not have been paid. The provider issues a refund check for the entire amount of the claim payment. During the claim adjustment process, the refund amount is applied to the claim and the original claim is adjusted to zero. The net payment to the provider is zero.

Partial Claim Refund

This adjustment occurs when the provider or EDS recognizes that a partial overpayment for a claim occurred. The provider issues a refund check for the amount of the overpayment. The refund amount is applied to the adjustment claim during processing. The historical data for the claim is adjusted.

Noncheck-related Adjustment

Underpayment Adjustment

This adjustment occurs when the provider seeks additional reimbursement for a claim. The net payment to the provider, when the adjusted claim amount is more than the original claim amount, is the difference between the original claim amount and the adjusted claim amount.

Overpayment Full Offset

This adjustment occurs when the provider or EDS recognizes that a claim should not have been paid. The provider or EDS requests that the overpayment amount be deducted from future claim payments to the provider. After the offset is processed the claim is adjusted to zero, and an accounts receivable (A/R) is established for the entire amount of the claim.

Overpayment Partial Offset

This adjustment occurs when the provider or EDS recognizes that a partial overpayment for a claim occurred. The provider requests that the overpayment amount be deducted from future claim payments. The historical data for the claim is adjusted. An A/R is established for the overpayment amount.

The EDS Adjustments Unit is responsible for performing all claim-specific adjustment transactions. Workflow graphics are included in this manual for clarification of this process. In addition, copies of Indiana*AIM* windows are displayed in this manual to provide a better understanding of the process being described.

Section 4: Incoming Adjustment Requests

Introduction

The provider typically initiates an adjustment, but they can also be requested from an internal or external party such as IFSSA or the EDS Customer Assistance Unit. An external initiator completes an adjustment request form and forwards it to the specified EDS adjustments post office box. An internal request is forwarded to the Adjustments team leader.

Adjustment requests are received in the EDS mailroom daily and are removed from the envelopes by mailroom staff. The requests are handled by one of the methods explained in the following sections.

Check-related Adjustments

Check-related adjustments are sent to the lockbox for deposit at the bank. If a check-related adjustment request is sent to EDS, it is immediately forwarded to the cash control clerk for deposit and entry in Indiana*AIM*. Refer to the *Finance Operating Procedures Manual* for further information about entering, depositing, and controlling checks in Indiana*AIM*.

Process for Misrouted Refund Checks for EDS Adjustments versus Health Management Services

HMS Refunds

Health Management Services (HMS) is a partner of EDS that performs back-end billing for Medicare and commercial insurances. HMS bills these companies for refunds due to EDS paying as primary in error. The types of HMS refunds received in the EDS Adjustments Department are from large Medicare companies. All refund checks for HMS should be sent to the following address:

EDS Refunds
P.O. Box 1937, Dept. 56
Indianapolis, IN 46206-1937

When the EDS Adjustments Department receives a copy of a refund check that belongs to HMS, the following steps are taken:

- Notify the EDS Finance director or the EDS HMS representative
- Delete the CCN number corresponding to the check. This is performed by the Finance control clerk

EDS Refunds

Refunds for check-related adjustments should be sent to the following address:

EDS Refunds
P.O. Box 1937, Dept. 104
Indianapolis, IN 46206-1937

On occasion, these checks arrive in Department 56, which is for HMS. HMS then receives these refund checks in error. HMS has agreed to return these checks to the

EDS Adjustments Department within 14 days of receipt. This will enable EDS to meet its contractual requirement of 45 days for processing all check-related adjustments.

Noncheck-Related Adjustments

Noncheck-related adjustment requests are forwarded to the batch control clerk in Claims Support the day of receipt.

Adjustment Mail Baskets

Incoming Adjustment Mail Basket

An adjustment analyst reviews adjustment mail received in this basket daily. The mail is separated by appropriate claim type. The basket is located on a filing cabinet shelf in the Adjustments unit. Below this basket on the next shelf are three trays labeled *Institutional*, *Crossovers,* and *Medical*. This is where the adjustment mail is separated. The morning of the following business day, the Claims Support Unit picks up the mail for microfilming.

Claim Support Research Basket

This basket is for claims that Claims Support requires assistance with to determine how to properly batch the claim. An adjustment analyst researches these claims daily and will either return them to Claims Support to batch or will send a letter to the provider asking the provider to submit the claim in an appropriate manner.

Batch Preparation

Refer to the *Finance Operating Procedures Manual* for details about batch preparation of check-related adjustment requests. Refer to the *Mailroom Operating Procedures Manual* for details about batch preparation of noncheck-related adjustment requests.

ICN Procedures

The cash control clerk assigns unique cash control numbers (CCNs) to check-related adjustments. The adjustment internal control number (ICN) for a check-related adjustment is assigned by the system after the adjustment is entered in Indiana*AIM* for processing. The CCN, not the ICN, is used as the unique identifier for the paper documentation. The CCN is maintained as part of the adjusted claim record for future reference. The components of the CCN are listed below:

- YY – Year of receipt
- JJJ – Julian date of receipt
- BBB – Batch number. For example: *905* to identify a Third Party Liability (TPL) batch or *910* to identify a miscellaneous batch.
- SSS – Sequence number within the batch (for example: 01200905000)

The batch number identifies the check type, such as TPL, drug rebate, or provider refunds. A list of batch numbers is located in *Appendix I.*

Noncheck-related adjustment requests are sorted into individual batches by claim type and filmed by mailroom personnel within one business day from the time the prepared batches are returned to the mailroom for filming. The adjustments are stamped with an ICN that is entered in Indiana*AIM* when the adjustment is initiated. This ICN number becomes the adjustment record.

The components of the adjustment ICN, both check-related and noncheck-related, are listed below:

- RR – Region
- YY – Year of receipt
- JJJ – Julian date of receipt
- BBB – Batch number
- SSS – Sequence number within the batch

Refer to the *Finance Operating Procedures Manual* for details about ICN assignment for check-related adjustment requests. Refer to the *Mailroom Operating Procedures Manual* for details about ICN assignment for noncheck-related adjustment requests.

Noncheck-related Adjustments (Region 50)

Noncheck-related adjustments are defined as provider requests for additional payment (underpayment adjustments), or provider requests for an overpayment amount to be deducted from future claim payments (offset adjustments). Offset adjustments are further categorized as full claim offsets or partial claim offsets.

The Adjustments analyst tracks adjustments through Indiana*AIM* from initiation to adjudication. The following section explains how noncheck-related adjustments are processed.

Data and Window Security

Authorization to initiate adjustments is limited to Adjustments Unit staff members and Finance Unit staff members. EDS or OMPP personnel can view adjustment-related data by accessing the *Adjustment Information* option at the **Paid, Denied, or Suspended header** for adjusted claims in Indiana*AIM*. This displays the *Claim Adjustment Xref* window and provides the following information:

- ICN of all versions of the claim, including previous adjustments to the claim
- Date adjusted
- Claim status
- System status
- Adjustment reason
- Processing analyst user identification (ID)

Inventory Control

Noncheck-related adjustments are batched, microfilmed, and stamped with an ICN number. The adjustments are logged into the *Noncheck-Related Inventory* window to add the request to the adjustment inventory on the *Adjustments Tracking Report*, and assigned to an adjustments analyst. Noncheck-related adjustment requests are monitored and aged from the ICN Julian date forward. The Adjustments analyst processes the adjustments in aged Julian date order, working the oldest adjustment request first. The inventory control function is the responsibility of the mailroom. Please refer to the *Mailroom Operating Procedures* for details.

Adjustments inventory is monitored through the *Aged Adjustment Listing Report*, the online *Adjustment Inventory* window, and through the data correction scheduler. Refer to the *Resolution of Claim Errors Operating Procedures Manual* for details about how to use the data correction scheduler and perform data corrections to suspended claims.

Adjustment Research

After the noncheck-related adjustment is added to the inventory, it is assigned to an Adjustments analyst for research and processing. The Adjustments analyst uses various resources to research an adjustment request. The following is a list of the most commonly used research tools:

- Indiana*AIM* Recipient Eligibility, Third Party Liability, and Provider Eligibility Databases
- Indiana*AIM* claim history
- Microfilm, if the claim is more than 36 months old
- Past remittance advice
- *HCPCS/CPT 4 Manual*
- *ICD-9 CM Handbook*

> *Note: Only paid claims can be adjusted. Denied claims are returned to the provider through the Return to Sender process. Refer to the Return to Sender procedures for additional information.*

If the request is valid, the Adjustments analyst accesses the most recent version of the paid claim online. To initiate an adjustment, the following procedures are followed:

1. Click **Claims** on the *Main Menu* and then **Inquiry** to open the *Claims Inquiry* window and access the paid claim.
2. Type the appropriate search parameters and click **Search**. The window displays all claims that meet the search parameters. If the claim is denied or suspended, it cannot be adjusted.
3. Highlight the paid claim and double-click **Select** to process an adjustment. The *Paid Header* of the selected claim displays all data from the Paid History Table.
4. Verify that the correct claim is shown, click on the *Options* drop-down list click, select **Adjustment Request**, and click **Non-check-Related**. The *Adjustment Header* window opens with data from the paid header.

5. Type the adjustment ICN printed on the adjustment request.
6. Type the appropriate adjustment reason indicating to the system the action to take. The reason code also generates an *Explanation of Benefit* message on the provider remittance advice. This notifies the provider of the adjustment action. The three types of noncheck-related adjustment reason codes are as follows:
   - *Underpayment* – Indicates to Indiana*AIM* that the adjustment is for an underpaid claim. Adjusted data must be typed.
   - *Full Offset* – Indicates to Indiana*AIM* that the entire amount of the claim is to be offset; therefore, no data is adjusted on the claim. The system automatically adjusts the claim to zero and establishes an A/R for the entire claim amount.
   - *Partial Offset* – Indicates to the system that only a part of the claim is to be offset; therefore, the claim must be adjusted and processed as an adjustment claim. Indiana*AIM* automatically establishes the A/R for the offset amount.
7. Apply corrections to the adjustment claim by highlighting the field to be corrected and retyping the data.
8. To change data on the detail of the paid claim, click **Continue** to access the *Adjustment Detail* window.
9. Type adjusted data, click **Save** and **Exit**. See the *Teleprocessing Users Guide Claims I through V* for details on *Adjustment* windows.

After an adjustment is saved, it is released in Indiana*AIM* for processing.

Processing

After an adjustment is saved, it is in a *release* status and is not available for online viewing until the status is updated. The adjustment claim can be accessed through the *Paid, Denied, or Suspended* windows.

Adjustment claims process during the nightly cycle. The adjustment claim pays, denies, or suspends. If the claim suspends, it is scheduled for data correction the following morning. The Adjustments analyst initiating the adjustment resolves data corrections for the adjustment. The morning scheduler automatically schedules work in aged order. Refer to data correction procedures in the *Resolution of Claim Errors Operating Procedures Manual* for more information.

If the adjusted claim payment is less than the original claim payment, an A/R file is established to offset future claim payments. The adjustment ICN becomes the A/R number on record. Please refer to *Section 5: Accounts Receivable* of this manual for details about A/R processing.

Nonclaim-specific Provider Refunds

Overview

Provider refunds are processed as nonclaim-specific transactions when one or more of the following situations occur:

- The provider refunded an overpaid amount for a claim that is no longer in 84-month history and therefore cannot be processed as a claim-specific adjustment transaction.
- The provider requested that EDS apply the refunded amount as a nonclaim-specific refund and has not supplied enough documentation to apply the refund as claim-specific.
- The provider requested the overpayment amount be processed as a claim adjustment, but has not supplied EDS with sufficient documentation to appropriately apply the refund. EDS notifies the provider that sufficient documentation was not received and the refunded dollar amount will be applied as nonclaim-specific unless documentation is received within the specified period.
- Pharmacies refunded payments for returned medications from LTC facilities.

Provider year-to-date 1099 earnings information is systematically updated to reflect the refunded amount.

Data and Window Security

Only the cash examiner, cash control clerk, or adjustments analyst can initiate nonclaim-specific provider refund transactions. Other Indiana*AIM* users are allowed to view inquiries for cash dispositions associated with nonclaim-specific provider refunds. Security is maintained through the user ID profile.

Transaction Control

Each cash receipt is assigned a CCN at the time of receipt. This number is used to monitor the cash receipt from its entry in Indiana*AIM* to its final disposition. After the cash receipt is entered in Indiana*AIM*, it is forwarded to the adjustment analyst for disposition. The adjustment analyst researches the refund request to determine the appropriate action to take. Reports are monitored weekly to ensure that all cash receipt dispositions, including nonclaim-specific provider refunds, are processed promptly.

Research

Each cash receipt is researched using the following resources to determine appropriate disposition for the refund:

- *Member History* – If documentation indicates that the refund is a result of overpayment of a claim, the recipient's most recent 84-month history is accessed. If the claim is in the 84-month history, the refund is processed as a claim-specific refund adjustment. Refer to adjustment procedures for additional information.
- *Archived History* – If the claim is no longer in the 84-month history, the archived history is used to determine the appropriate refund disposition amount to be applied to the provider's account.
- *Member Detail* – If further research is required, recipient history is used to determine if previous adjustments were made to the claim. This information helps the cash examiner determine the appropriate refund amount.

Cash Receipt Disposition

Nonclaim-specific refund transactions are processed through the *Cash Receipt Disposition Maintenance* window. Follow these steps to enter the disposition transaction:

1. At the *Main Menu*, click **Financial**. At the *Financial Menu*, click **Cash Receipts** to access the *Cash Receipt Search* window.
2. Type in the CCN and click **Search** to access the *Check Log* window for the appropriate CCN.
3. Highlight the appropriate NDC.
4. Click **Select**.
5. Click **Dispositions** to access the *Cash Receipt Disposition* window.
6. Click **New** to access the *Cash Receipt Disposition Entry* window to type in a new disposition amount.
7. Click the **Nonclaim-specific Refund** reason code from the drop-down box, type in the disposition amount, and the RID number.
8. Click **Save** and **Exit**.

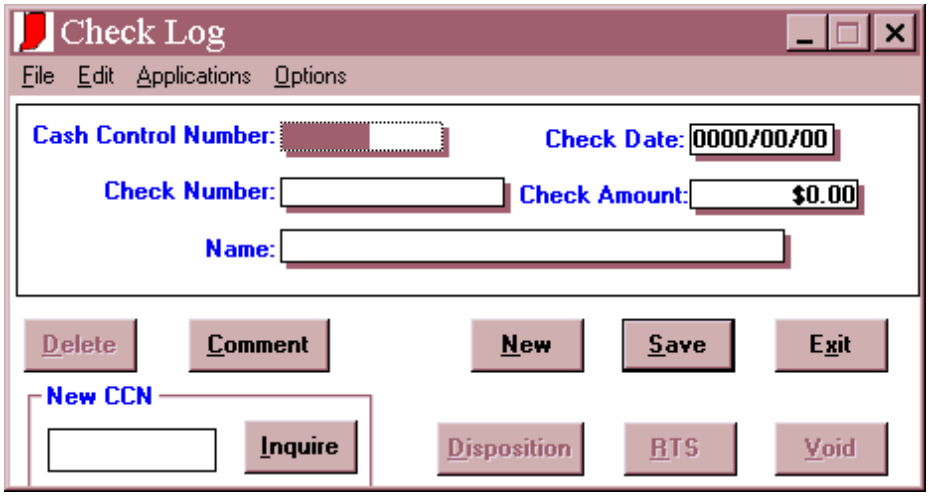


Figure 4.1 – Check Log Window

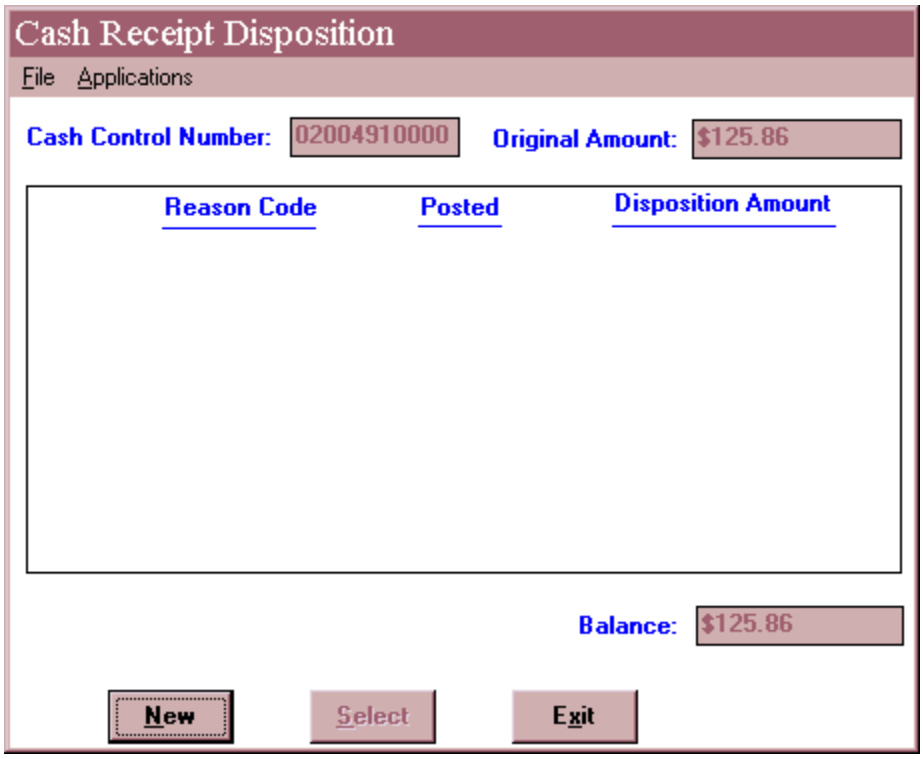


Figure 4.2 Cash Receipt Disposition Window

Indiana*AIM* uses the reason code to post the refunded amount to the provider account and update the provider year-to-date 1099 net earnings data.

Check-related Adjustments – Refunds (Region 51)

Overview

Check-related adjustment requests are cash receipts received and processed as claim-specific refunds to the Indiana Health Coverage Programs (IHCP). The refunded dollar amount is posted to the specific claim when the adjustment is processed in Indiana*AIM*. A reason code that indicates the source of the refund is typed in the adjustment record. This allows the system to categorize the refunds into provider, Surveillance and Utilization Review (SUR), and TPL recoveries for cash management reporting.

Data and Window Security

Authorization to initiate an adjustment is limited to Adjustment and Finance staff. Other EDS or OMPP personnel who wish to view adjustment-related data can access the *Adjustment Information* option at the *Paid, Denied, or Suspended* header for adjusted claims. The *Claim Adjustment X-ref* window displays the following information:

- ICN of all versions of the claim, including previous adjustments to the claim

- Date adjusted
- Claim status
- System status
- Adjustment reason
- Processing analyst user ID

To view cash receipt information associated with an adjustment, the user can access the *Cash Receipt Xref* window by clicking the **Option** drop-down box for the paid, denied, or suspended claim. This window displays the CCN, sequence, and disposition amount.

Inventory Control

Check-related adjustments are added to the adjustment inventory as dispositions are entered in Indiana*AIM*. Each cash disposition entered with a claim-specific reason code is logged and reflected in the total adjustment inventory count on all reports. As the adjustment is processed, it is removed from adjustment inventory.

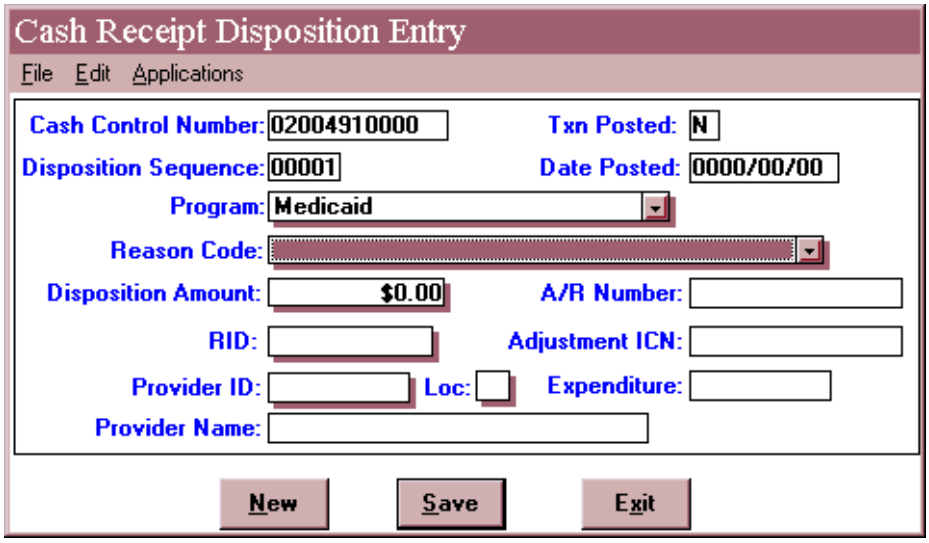


Figure 4.3 – Cash Receipt Disposition Entry Window

Before a claim-specific check-related adjustment can be initiated, the associated cash disposition must be entered. Use the following steps to enter the cash receipt disposition:

1. At the *Main Menu* click **Financial.** At the *Financial Menu* click **Cash Receipts** to access the *Cash Receipt Search* window.
2. Type the CCN and click **Search** to access the *Check Log* window for the appropriate CCN.
3. Highlight the appropriate CCN.
4. Click **Select**.

5. Click **Dispositions** to access the *Cash Receipt Disposition* window.
6. Click **New** to access the *Cash Receipt Disposition Entry* window and enter a new disposition.
7. Click the **Claim-specific Refund Adjustment** reason code from the drop-down menu, and type the disposition amount, and the RID number, which is optional.
8. Click **Save** and **Exit**.

Adjustment Research

After the cash receipt is processed, the adjustments analyst researches and initiates the adjustment. The cash examiner uses various resources to research an adjustment request. The following is a list of the most commonly used research tools:

- The Indiana*AIM* Recipient Eligibility, Third Party Liability, and Provider Eligibility databases
- Indiana*AIM* claim history
- Recipient detail microfilm, if the claim is more than 84 months old
- Past remittance advice
- *HCPCS/CPT 4 Manual*
- *ICD-9 CM Handbook*

> *Note: Adjustments can only be made to paid claims. Claims that have been denied cannot be adjusted and are returned to the provider through the Return to Sender process. Refer to the Return to Sender procedures for additional information.*

If the request is valid, the Adjustments analyst accesses the most recent version of the paid claim in Indiana*AIM*. To initiate an adjustment, use the following steps:

1. To access the paid claim, click **Claims** at the *Main Menu* and **Inquiry** at the *Claims Menu*. This opens the *Claims Inquiry* window.
2. Type in the appropriate search parameters and click **Search**. The window displays all claims that meet the search parameter. If the claim selected is denied or suspended, it cannot be adjusted.
3. Highlight the paid claim to be adjusted and double-click **Select**. The *Paid* header of the claim to be adjusted displays data from the paid history table.
4. Verify the correct claim has been highlighted and click **Adjustment Request** and **Check-related** from the *Options* drop-down menu. The *Check-related Adjustment Request* window is displayed.
5. Type in the CCN for the cash receipt and click **Search.** All dispositions for the cash receipt are displayed.
6. Highlight the cash disposition sequence for the adjustment and click **Select**. This links the cash disposition sequence to the adjustment record.

> *Note: Only dispositions displayed as **Select Available – Yes** can be applied to the adjustment record.*

7. The Indiana*AIM* system displays the *Adjustment Header* window with data from the paid header.
8. Indiana*AIM* correctly processes the adjustment and generates a message for the provider's remittance advice in the form of an Explanation of Benefit. This notifies the provider of the adjustment action. The two types of check-related adjustment reason codes are listed below:

- *Full Refund* – Indicates to the system that the entire amount of the claim is refunded; therefore, no adjustment of data is required. The system automatically adjusts the claim to zero and applies the refunded amount.
- *Partial Refund* – Indicates to the system that only a part of the claim is refunded; therefore, the claim must be adjusted and processed as an adjustment claim. The system automatically applies the refunded amount as indicated on the cash receipt disposition record.

9. Apply corrections to the adjustment claim by highlighting the field to be corrected and retyping the data.
10. To change data on the detail of the paid claim, click **Continue** to access the *Adjustment Detail* window.
11. Type in adjusted data, then click **Save** and **Exit**. Refer to the *Teleprocessing Users Guide – Claims* for *Adjustment* window details.

After an adjustment is saved, it is released for processing in Indiana*AIM.*

Processing

When an adjustment is in a *release* status it is not available for online viewing until the following morning. The adjustment claim can be viewed through the appropriate *Paid, Denied, or Suspended* windows.

Adjustment claims process during the nightly cycle. During the first batch cycle, Indiana*AIM* automatically generates the adjustment ICN for the check-related adjustment. The adjustment continues to process and pays, denies, or suspends. If the claim suspends, it is available for data correction the following morning. The adjustment analyst who initiated the adjustment resolves data corrections for adjustment claims. The morning scheduler automatically arranges the workflow in aged order. Refer to data correction procedures in the *Resolution of Claim Errors Operating Procedures Manual* for additional information.

Return to Sender

Noncheck

If an adjustment request is determined to be invalid and cannot be adjusted, the user clicks **Return to Sender (RTS)** at the *Paid Claim* header on the **Options** tool bar to initiate an RTS letter. At the *RTS* window, the user types the provider number and the reason code, which determines the letter generated. The letters are printed in the Adjustments Unit daily and are merged with the documentation for mailing.

Check

If an adjustment is determined to have insufficient documentation and cannot be adjusted, the user clicks the **RTS** button, located in the *Cash Disposition* window. The user types the provider number and selects the reason that determines why the letter was generated. The letters are printed in the Adjustments Unit daily and are merged with the documentation for mailing.

Section 5: Accounts Receivable – Setup/Maintenance

Overview

A provider A/R is automatically established in Indiana*AIM* when the original payment was more than the adjusted claim payment. The A/R deducts the amount due the IHCP from future claim payments to the provider. In addition, an A/R can be manually established through the *Accounts Receivable Entry* window. A manual A/R is established for the following situations:

- A partial payment is issued to a provider. The A/R is established to deduct the partial payment amount from future payments to the provider.
- A nonclaim-specific offset is initiated through the Surveillance and Utilization Review (SUR) Unit at Health Care Excel (HCE).
- A claim-specific offset is requested by the provider, for a claim no longer in active history because it is over 84 months old.
- A pharmacy provider requested an A/R be established for returned medications from LTC facilities.

Indiana*AIM* establishes an individual A/R for each offset adjustment or manual setup. This allows EDS and the OMPP to track and control aging receivables. An established A/R is satisfied by deductions from weekly claim payments to the provider. Indiana*AIM* automatically satisfies A/R in oldest to newest order. A provider can submit a check to satisfy an existing receivable.

Data and Window Security

Authority to set up and maintain provider A/Rs is limited to the Adjustments Unit staff and the Finance Unit staff. Other Indiana*AIM* users can inquire about provider A/R information, but cannot update any information. Security is controlled with the user ID profile.

Completing A/R Form

The *Accounts Receivable* form includes the following information:

- *Submitted by* – Name of person completing form
- *Date* – Date form completed
- *Provider Name* – Name of provider
- *Provider Number* – Provider ID number
- *Location* – Location code associated with the provider ID number
- *Program Code* – Usually Medicaid
- *Reason for Setup* – Reason the A/R is needed and reminder to attach documentation

- *Setup Amount* – Total amount to deduct from future claim payments to the provider
- *Number of Adjustments* – Number of adjustments included in total setup amount
- *Dates of Service* – From and through dates of service for each adjustment

Complete the form and submit noncheck-A/Rs to the specialized adjustment analyst. Include the necessary explanation and attach documentation to clearly explain why the A/R was created. The documentation must validate the A/R. Check-related A/Rs are processed through the *Cash Disposition* window. Select disposition and use the following reason: Check received for claims no longer in history.

Entering an A/R

The procedure to enter an A/R in Indiana*AIM* includes the following steps:

1. At the *Main Menu*, click **Financial**
2. Click **Accounts Receivable**
3. Select **New** to display the *A/R Setup Maintenance* window
4. Create and type in the **A/R number**. A/Rs begin with region 60 and are typed in RRYYJJJBBBSSS format.
   - *60* – Region 60 indicates an A/R
   - *YY* – Two-digit year (00)
   - *JJJ* – Three-digit Julian date the A/R was established
   - *BBB* – Three-digit batch number. Adjustment batch numbers are 950, 951, and 952.
   - *SSS* – Three-digit sequence number indicating the location of A/R in the batch. Valid ranges are 000 to 999.
1. Type the provider number and location. The interest accrual date automatically populates with the current date, which is also the date deductions begin. This date can be changed to a future date.
2. Click **Program**
3. Click the correct **Reason Code** from the drop-down list
4. Type in the setup amount with a decimal point between dollars and cents
5. Type **1** in the Recoup Percentage field, so 100 percent of the A/R is deducted from the next claims payment
6. Verify all information, and click **Save**

A/Rs do not need to be activated by a supervisor. All A/Rs completed by 6 p. m. Friday appear on the remittance advice (RA) the following Tuesday.

Provider Accounts Receivable Manual Setup

Figure 5.1 – Provider Accounts Receivable Setup/Maintenance Window

To set up a manual A/R at the *Main Menu*, click **Financial** and **Accounts Receivable** to open the *Provider Accounts Receivable Selection* window. Click **New** to access the *Provider Accounts Receivable Setup/Maintenance* window. Type in the following data as needed:

- Accounts Receivable Number – RRYYJJJBBBSSS format
- Effective Date – Start date for deductions from future claim payments. If nothing is typed, the system defaults to the setup date.
- *Set-up Date* – System-generated to the entry date.
- Provider Number

Click appropriate **Program Code** from the drop-down list.

Click appropriate **Reason** from the drop-down list.

- *Set-up Amount* – Original amount of the A/R.

- *Recoupment Amount* – Dollar amount to be recouped from the claim payment cycle. If there is not a set dollar amount, leave blank.
- *Recoupment Percent* – Percentage of the weekly checks written, and recouped each payment cycle. The recoupment amount and recoupment percent fields are mutually exclusive. If there is not a designated recoupment percent or recoupment amount, type **100 percent** in the recoupment percent field. Indiana*AIM* deducts the full amount from the next payment.

After all information is complete, click **Save** and **Exit**.

Entering A/R Comments

To enter comments about the A/R setup transaction, click **Comments** at the *Provider Accounts Receivable Setup/Maintenance* window to access the *Provider Accounts Receivable Comments* window. Then type in the date in CCYY/MM/DD format and any information deemed necessary. Comments must be entered if the A/R is established because the claim to be adjusted is no longer in the 36-month history. To maintain a historical record of why the A/R was established, indicate the original claim and the reason it could not be adjusted as a claim-specific transaction.

Provider Accounts Receivable Update/Inquiry

A user can inquire about a provider A/R but cannot alter the A/R file. User ID controls access to inquiry in the Indiana*AIM* Security system. In addition, only authorized users can make updates to existing A/R records. The only fields that can be updated are:

- Effective date
- Recoupment amount
- Recoupment percentage

To update or inquire about a provider A/R file, click **Financial** at the *Main Menu* and **Accounts Receivable** at the *Financial Menu*. The *Provider Accounts Receivable Selection* window will then appear. The appropriate A/R can be located by entering the following information:

- Provider number
- A/R number
- Reason
- Program
- Status
- Effective from and through dates

Type one or more of the search criteria data elements and click **Search**. A list of all A/Rs that match the search criteria is displayed. To open the *Provider Accounts Receivable Setup/Maintenance* window, highlight the A/R to be updated or viewed, and click **Select** or double-click the A/R to be updated or viewed.

The original setup information is displayed. To update a field, highlight it, make the necessary changes, and click **Save** and **Exit**.

Manual Provider Accounts Receivable Disposition Entry

Dispositions are systematically applied to A/R as the provider claim payments are offset. In some instances, it is necessary to manually process the A/R file. Manual dispositions are required in the following situations:

- State directed increase
- SUR directed increase
- State directed decrease
- SUR directed decrease
- Cash receipt applied to principle (decrease)
- Cash receipt applied to interest (decrease)
- Provider over refund applied (decrease)
- A/R liquidation – State directed (decrease)
- A/R write-off – State directed (decrease)
- Interest applied to aging receivable (increase)
- Interest applied to aging receivable – SUR (increase)
- A/R established for wrong provider
- Stop paid system check applied to aging A/R

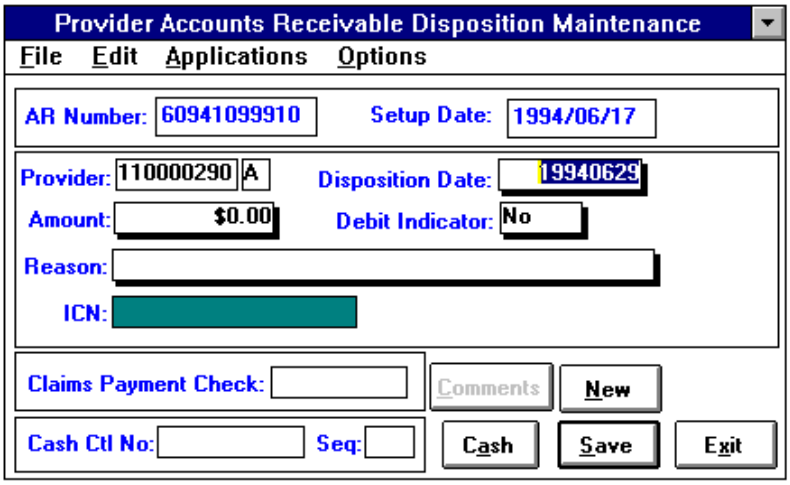


Figure 5.2 – Provider Accounts Receivable Disposition Maintenance Window

To enter a provider A/R disposition transaction:

1. Access the *Provider Accounts Receivable Setup/Maintenance* window for the appropriate A/R.
2. Click **Disposition** at the *Provider A/R Setup/Maintenance* window to access the *Provider Accounts Receivable Disposition History* window. This window

displays a list of the dispositions applied to the A/R to date and the remaining due on the A/R.

3. Click **New** to access the *Provider Accounts Receivable Disposition Maintenance* window. The A/R number, setup date, and provider number are generated from the *A/R Setup/Maintenance* window.

Complete or verify the information requested as follows:

1. Disposition date – System-generated to the current date
2. Amount – Amount to be dispositioned, either positive or negative
3. Click the appropriate **Debit Indicator** from the drop-down list. Select **Yes** for decrease or negative amounts or select **No** for increase or positive amounts.
4. Click the appropriate reason from the drop-down list
5. Click **Cash** to access the Checks related to *Provider A/R Dispositions* window if the reason for the disposition is a cash receipt.
6. Type in the CCN of the associated cash receipt and click **Search**. All cash disposition entries for the cash receipt display.
7. Highlight the cash disposition related to the A/R and click **Select** or double-click the appropriate cash disposition detail. This links the cash disposition to the A/R. Click **Exit**
8. Click **Save** and **Exit** the *Provider Accounts Receivable Disposition Maintenance* window

To enter comments relating to the A/R dispositions, click **Comments** at the *Disposition Maintenance* window to access the *Provider A/R Disposition Comments* window. Type in the date using CCYY/MM/DD format and any comments deemed necessary. Click **Save** and **Exit**

Provider Accounts Receivable Disposition Inquiry

To inquire about a manually or systematically established A/R, click **Financial** at the *Main Menu* and **Accounts Receivable** at the *Financial Menu*. This opens the *Provider Accounts Receivable Selection* window. The following search criteria can be typed into this window to locate the appropriate provider A/R:

- Provider number
- A/R number
- Reason
- Program
- Status
- Effective from and through dates

Type in one or more of the search criteria data elements and click **Search**. A list of all A/R matching the search criteria is displayed. To open the *Provider Accounts Receivable Setup/Maintenance* window, highlight the A/R to be viewed and click **Select** or double-click the A/R to be viewed.

Click **Dispositions** to access the *Provider Accounts Receivable Disposition History* window. The following search parameters can be entered:

- A/R number
- Provider ID
- Reason
- Applied from and through – Lists dispositions applied during the date range entered
- Check – Displays dispositions applied during the weekly claims payment cycle. The check number of the payment cycle appears in this field.

Logging Accounts Receivables

All A/Rs are logged weekly in a Microsoft Excel spreadsheet that is separated by months. This spreadsheet is mailed to the Finance director for review on a weekly basis. Figure 5.3 is an example of this spreadsheet.

Figure 5.3 - Accounts Receivable Spreadsheet

Provider Number	A/R #	Amount	# Claims	DOS	Date Applied
100234567A	6002123456789	$5.25	1	1/6-6/29/98	5/6/2002
100245678A	6002124567891	$68,724.00	1	5/1-31/01	5/10/2002
100256789A	6002125678912	$156.88	2	8/14/96-10/3/96	5/10/2002
100267892A	6002126789123	$150.00	1	2/12/1998	5/24/2002
100278912B	6002127891234	$2,177.28	1	4/1-30/96	5/24/2002
100289123A	6002128912345	$875.78	1	4/17-19/95	5/24/2002
100291234A	6002129123456	$11.04	1	3/8-9/98	5/24/2002
100345678A	6002134567891	$97.20	1	10/31/1994	5/24/2002
100356789B	6002135678912	$472.00	1	6/30/1998	5/24/2002
100367891B	6002136789123	$713.87	1	2/16-28/98	5/24/2002
100378912A	6002137891234	$118.57	2	6/17-7/3/96	5/24/2002
100389123B	6002138912345	$3,389.52	2	10/1-31/98	5/24/2002
100391234A	6002139123456	$809.01	7	6/22-11/30/98	5/24/2002
100456789A	6002145678912	$12.00	1	3/8/1995	5/29/2002
100467891A	6002146789123	$4,655	20	1/4/96-11/21/96	5/29/2002

Section 6: Expenditures

Expenditure Payout

Overview

Expenditures are system payments to providers not linked to a claim, and display as a *payout* on the provider remittance advice. All expenditure payout transactions, both system-generated and manually issued, are maintained in Indiana*AIM*. Strict controls and procedures have been established for processing system and manual payouts. The process is designed to ensure every dollar disbursed by EDS on behalf of the IHCP is tracked to provide full accountability. EDS has the flexibility to issue a payout through the system or to issue a manual check.

Data and Window Security

Expenditure payout transactions can be initiated by various entities as previously stated. However, activation and release of expenditure transactions can only be completed on approval of the Adjustments supervisor or TPL manager. Limited access ensures integrity of the disbursement of funds. Other users can view expenditure transactions only for inquiry. Security is controlled with the user ID profile.

Transaction Control

All expenditure payout requests are date stamped on the day of receipt and entered in Indiana*AIM* within five business days. When expenditures are entered in Indiana*AIM*, a system-generated number is assigned and the number is written on the paper copy of the request. If the payout transaction is the result of an over-refund, the control number is also written on the cash receipt documentation. All paper documentation is periodically microfilmed and stored off-site.

Authorization Control

Various departments in EDS can initiate expenditure transactions. To ensure accountability, all expenditures entered in Indiana*AIM* require the approval of the Adjustments supervisor and the TPL manager before they are released for processing and payment. Expenditure payouts for partial payments also require the approval of the customer assistance manager, account manager, and authorized IFSSA agents. Refer to the *Financial Operating Procedures Manual* for additional information.

Completing an Expenditure Form

The expenditure form requires the following information:

- *Submitted by* – Name of person completing expenditure form

- *Date* – Date expenditure form completed
- *Payee Name* – Provider or payee name
- *Provider Number* – Provider or payee number and location
- *Address* – Provider or payee street address
- *City, State, ZIP* – Provider's city, state, and ZIP code
- *Payout Amount* – Amount due to provider
- *CCN* – Cash control number associated with a check-related refund
- *Check Number* – Number of the check associated with a check-related refund
- *Check Amount* – Total check amount of the provider check-related refund
- *Justification* – Reason for expenditure with documentation

Complete the *Expenditure Check List* at the bottom of the form, checking applicable boxes. Include the explanation and any documentation that explains why the expenditure occurred. The documentation must validate the expenditure. The completed form is submitted to the Adjustments supervisor for approval.

*Entering an Expenditure in Indiana*AIM

An expenditure request is entered in Indiana*AIM* after the Adjustments supervisor approves it. The steps for entering expenditures are listed below:

1. Click **Financial** at the *Main Menu*
2. Click **Expenditure TXNs**
3. Click **New**
4. Click **Provider** to display the *Provider* window
5. Type in the provider number to display the provider's name and address
6. Click **Save** to display the *Expenditure Maintenance* window
7. Type in the expenditure payout amount with a decimal point between dollars and cents
8. Click **Reason** and select an option from the drop-down list
9. Click **Program** and select a program from the drop-down list
10. Create and type the created six-digit number in the *State Letter Number* field. (Use this option if you do not have a CCN#)
    - CCN and batch sequence numbers varies by what number expenditure is dispositioned under in cash receipt window.
11. Verify all information and click **Save**
12. After the information is saved, the expenditure number displays at the lower left of the screen, above *Date Added*. Write the expenditure number in the space provided at the top of the expenditure form for future reference.
    - A comment must be entered. Click **Comment**; enter necessary information obtained from *Expenditure Request*. Click **Save**.

After the expenditure is entered, the paperwork is forwarded to the financial manager for approval and activation. Expenditures activated by 6 p. m. Friday are included in the remittance advice the following Tuesday.

Section 7: Adjustment Reports

Note: Research is ongoing to update this section. The next edition will reflect these changes.

Introduction

The following is a description of all adjustment transaction reports generated from Indiana*AIM*. An example of each report and a complete definition can be found in the *Master Report Definitions Manual*.

Adjustments Inventory Summary (ADJ-2000-W)

The *Adjustments Inventory Report* summarizes total adjustments initiated, returned to sender, and finalized with a beginning and ending balance calculated weekly. This report sorts data by claim type and region, with totals for each claim type and summary totals for all claim types.

EDS uses this report in conjunction with the *Aged Adjustment Analysis and Cycle Time Compliance Reports* to monitor and control adjustment inventory to ensure that all adjustments are processed in a timely manner. It also supplies EDS with data to track inventory trends.

Aged Adjustment Listing by User ID (ADJ-2001-W)

The *Aged Adjustment Listing – By User ID* lists all outstanding adjustments per user by claim type and ICN aged order. This report also helps the Adjustments analysts and the Adjustments supervisor monitor aged adjustments.

Aged Active Adjustments Analysis (ADJ-2003-W)

This report lists the previous, current, and average number of days in each category, as well as the current balance. There are six time segments ranging from zero to greater than 91 days. The information on this report is for adjustment requests only.

EDS and IFSSA use the *Aged Active Claim Analysis – Adjustments Report* to monitor the status of adjustment requests in suspense by claim type. Claims suspended for long periods receive a high priority for resolution. Large groups of claims within a certain suspense location code also receive high priority. Using this report, tracking location codes, and the age of suspended claims, helps to identify trends.

EOB Denial Analysis List (ADJ-2004-W)

This report lists the error code, description, and the EOB that posted a denied claim. The total number of denials for each error code is reported. The number of denials per claim type is reported in the *Claim Type* column. The grand total of automatically and manually denied claims is also included at the end of the report.

EDS and the IFSSA use the *EOB Denial Analysis List* to determine the number of adjustment requests that automatically and manually denied in the weekly cycle. The error status codes (ESC) that cause claims to automatically deny can be found in the *Edit/Audit Disposition Table*. ESCs that cause claims to manually deny are set to suspend on the *Error Disposition Table*.

Edit/Audit Override Analysis (ADJ-2005-W)

This report lists all adjustment overrides by user ID. This report also indicates the number of overrides by error code, analyst, and claim type.

EDS and the IFSSA use this report to monitor the frequency of overrides.

Adjustments Return to Sender Summary (ADJ-2006-D)

The *Return to Sender Log* lists all adjustment ICNs and CCNs returned weekly.

EDS uses this report to monitor all returned documentation and requests for additional information.

Error Analysis by Provider Number (ADJ-2007-W)

This report lists the top ten provider numbers and the top five error codes associated with adjustment claims for a given reporting week.

EDS uses the *Error Analysis by Provider Number Report* to examine the top ten providers encountering errors in the adjustments processing system. This report is forwarded to the Customer Assistance Unit so the affected providers can be notified. The main purpose of this report is for provider education.

Error Analysis by Suspended Error Code (ADJ-2008-W)

This report shows the number of adjustments per claim type that are suspended per edit. All edits are listed in the error number column along with a brief description. For each edit, the total number of suspensions for each adjustment region is reported along with the total number for each claim type. In addition, a summary of all regions and a grand total are calculated.

EDS and the IFSSA use the *Error Analysis by Error Code Report* to monitor weekly edit suspensions for each adjustment region. When high edit counts are identified, research determines if edits need revision or if providers are experiencing billing

problems. If a provider is identified as having problems, the Customer Assistance Unit can contact the provider to resolve the problems.

Error Analysis by Forced Error Code (ADJ-2009-W)

This report lists the error code, the description, and the number of errors per claim type that were forced through the system. This report is sorted by adjustment region code with a total for each error status code.

EDS and the IFSSA use the *Error Analysis by Forced Error Code Report* to monitor the effectiveness of the error codes. The report is also used to determine if the error codes are necessary, based on the volume of claims forced to adjudicate and pay.

Weekly Adjudicated Cycle Time Analysis – Adjustments (ADJ-2010-W)

This report lists adjustment claim counts by claim type and the number of days it took to reach final status. Final status is achieved when claims reach the one of the following locations:

- 66 – Denied
- 97 – Approved to pay (claim payment hold)
- 98 – Approved for payment
- 99 – Paid

This report also lists the percentage of total claim volume by days elapsed and the average age of claims to final status. The data reported spans 30 days.

EDS and the IFSSA use the *Weekly Claim Adjudication Cycle Time Analysis – Adjustments* report to monitor time spent on adjustment processing to ensure that full cycle time compliance is met.

Mass Adjustment Process Summary – LTC Retro Rate (ADJ-2070-W)

This report lists all LTC retroactive rate adjustment transactions initiated and processed during the current weekly financial cycle.

EDS uses this report to validate the adjustment transactions processed against the original retroactive rate adjustment notification sent by the rate-setting contractor, currently Myers and Stauffer L.C. In addition, EDS and the IFSSA use the report to record the LTC retroactive rate transactions processed during the weekly cycle.

Mass Adjustments Process – LTC Retro Rate Claims Listing (ADJ-2071-W)

The Mass Adjustment Process – LTC Retro Rate Claim Listing is produced as both an online and CRLD report that lists all claims adjusted during the current weekly cycle for LTC retroactive rate adjustments. The report is sorted by provider number and lists each claim adjusted for a provider, the number of claims adjusted, and the number of members associated with the claim adjustments.

EDS and the IFSSA use this report to validate all claims processed for a specific provider during the weekly cycle. In addition, the Customer Assistance Unit and other areas have access to this report online to assist with retroactive rate adjustment-related questions.

Mass Adjustments Processed Summary (ADJ-2072-W)

The Mass Adjustment Process – LTC Retro Rate Claim Listing is produced as an online and CRLD report and lists all voids, retro rates, and mass adjustments that were adjusted during the current weekly cycle. The report is sorted by provider number and lists each claim adjusted by region, the number of claims adjusted, and the number of providers associated with the claim adjustments.

EDS and IFSSA use this report to validate all claims processed for each region during the weekly cycle. In addition, the Customer Assistance Unit and other areas can view this report online to assist with retroactive, rate adjustment-related questions.

Section 8: Performance Standards

Indiana*AIM* Performance Standards

Department/Unit:	Adjustments Unit
Performance Standard:	Review and adjudicate 100 percent of all requests for adjustments within forty-five days of receipt.
RFP Requirement No.:	2.5.1.9.3.f
Quality Process Frequency:	Weekly
Personnel:	Adjustments supervisor
Procedure:	Adjustment requests are entered in Indiana*AIM* within five business days of receipt. Once all research has been completed, the adjustment is initiated for batch processing. EDS uses a continuous batch processing cycle that enables the user to resolve claim errors on the next business day and re-release the adjustment into the cycle to adjudicate. This continuous batch processing cycle minimizes the number of days taken to fully adjudicate an adjustment.
Monitoring:	The Adjustments supervisor monitors adjustments inventory using the daily Data Correction work scheduler. In addition, the following reports are viewed weekly and aged claims are prioritized. • ADJ-2010-W • ADJ-2003-W • ADJ-2001-W • ADJ-2000-W • FIN-1004-D • FIN-1008-D

Section 9: Quality Management

Introduction

Quality management comprises numerous activities, including ongoing quality assessment. This is not a static process, but a dynamic one that involves identification, assessment, feedback, and improvement. As one level of service or performance is improved, another is targeted. These activities directly correspond to goal setting at the individual or unit level.

The following section outlines overall quality assessment factors that are applicable for the long term because of the nature of their overall application. Other activities are identified for assessment and improvement at least quarterly.

Indiana*AIM* Quality Management

Department/Unit:	Adjustments Unit
Performance Standard:	Ensure that new staff can perform assigned activities per defined procedures and requirements
Quality Process Frequency:	Daily, until acceptable performance levels are maintained
Personnel:	Lead adjustments analyst
Procedure:	Select a sample of work from each activity performed. Samples vary based on job position
Monitoring:	Review for the following: • Accuracy of data input • Accuracy of data analysis • Appropriate follow-up • Application of all necessary steps and procedures

Department/Unit:	Adjustments Unit
Performance Item:	Perform accurate adjustment processing
Quality Process Frequency:	Weekly
Personnel:	Adjustments analyst and team lead

Procedure:

Randomly pull eight completed adjustment claim samples per analyst per week.

Monitoring:

Review for the following and note any discrepancies:

- Timeliness of processing
- Accurate *Reason Code* assignment
- Accurate historical data adjustment
- Appropriate adjudication

Section 10: Sample Letters

RTS Letter # R03 – Missing Refund Check Documentation

Report Definition Information

Part I

Functional Area: Adjustments/Financial

Report Number: FIN-9003-D

Report Title: RTS Letter # R03 – Missing Refund Check Documentation

Description of Information:

This letter is generated through the online windows. The user enters the provider number or payee and address. The information entered populates the Return to Sender Letter and returns with a copy of the check requesting documentation.

Purpose:

To obtain documentation from the payee explaining why the money was sent.

Sort Sequence:

None

Distribution:

To	Media Type	Copies	Frequency
Provider	Paper	1	On request

950 North Meridian Street, STE 1150
Indianapolis, Indiana 46204-4288

(317) 488-5000
Fax: (317) 488-5169

Date

Provider Name
Address
City, State Zip Code

ATTN: Patient Accounts
RE: Cash Control Number

Dear Provider:

EDS has received your check dated ***(check date)*** for the amount of ***(amount).***
EDS deposited your refund check but was unable to process your refund with the information given. The following information is **required** in order to appropriately apply a refund:

- Completed adjustment request form for each claim specific refund
- Copy of the remittance advice (RA) page detailing the original claims payment

In addition to the above documentation, please provide the following:

- ❑ Copy of Medicare Remittance Notice (MRN) or commercial carrier explanation of benefits (EOB) if applicable
- ❑ Copy of patient's deductible *FI 008A* Form to indicate spenddown
- ❑ Copy of patient's liability amount for month affected
- ❑ Other

Please mail or fax the required supporting documentation along with a copy of this letter to the following address:

EDS – Adjustments
P.O. Box 7265
Indianapolis, IN. 46207-7265
Fax: (317) 488-5169

A response is needed in ten business days by mail, fax, or phone. Upon receipt of the required documentation, your refund check will be applied appropriately.

If you have any questions about this matter please contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 or visit the IHCP Web site at http://www.indianamedicaid.com/. Thank you for your participation in the Indiana Health Coverage Programs.

Sincerely,

Adjustment Analyst
Adjustment Unit
Enclosure(s)

950 North Meridian Street, STE 1150
Indianapolis, Indiana 46204-4288

(317) 488-5000
Fax: (317) 488-5169

Date

Provider Name
Address
City, State Zip Code

ATTN: Patient Accounts
RE: Cash Control Number

Dear Provider:

Thank you for your recent paid claim adjustment request. This letter is to inform you that a full recoupment has been performed on the claim listed above due to one of the following reasons:

- Commercial insurance paid more than the Indiana Health Coverage Programs (IHCP) allowed amount. Therefore the full IHCP payment was due. See *Chapter 5* of the *IHCP Provider Manual* for more information.
- Medicare claims were not billed as crossovers. These claims must be resubmitted with the Medicare Remittance Notice (MRN) to ensure appropriate processing and payment. See *Chapter 5* of the *IHCP Provider Manual* for more information.

An accounts receivable will set up for the outstanding balance due. This amount will deduct from a future payment.

If you have any questions about this matter please contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 or visit the IHCP Web site at http://www.indianamedicaid.com/. Thank you for your participation in the Indiana Health Coverage Programs.

Sincerely,

Adjustment Analyst
Adjustment Unit

Enclosures

950 North Meridian Street, STE 1150
Indianapolis, Indiana 46204-4288

(317) 488-5000
Fax: (317) 488-5169

Date

Provider Name
Address
City, State Zip Code

ATTN: Patient Accounts
RE: Cash Control Number

Dear Provider:

This letter is regarding the previous correspondence EDS sent you about the check dated ***(check date)*** for the amount of ***(check amount).***

To date, EDS has not received sufficient documentation to process your adjustment request. Therefore, this final request is being sent with the attached documentation that was previously sent. If the information previously requested is not received within 10 business days of receipt then a **non-claim specific adjustment** will be set up in the amount of ***($ amount)***. When the refund is put in non-claim specific status, EDS will not be able to alter the refund.

The non-claim specific adjustment will appear on a future remittance advice. A nonclaim specific adjustment is a credit to your tax identification number, but will not be applied to a specific claim. The nonclaim specific adjustment will appear on your 1099-tax form at the end of the year as a credit.

If you have any questions about this matter please contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 or visit the IHCP Web site at http://www.indianamedicaid.com/. Thank you for your participation in the Indiana Health Coverage Programs.

Sincerely,

Adjustment Analyst
Adjustment Unit

Enclosures

RTS Letter # R20 – Adjustment Request Past Filing Limit

Report Definition Information

Part I

Functional Area: Adjustments/Financial

Report Number: FIN-9020-D

Report Title: RTS Letter # R20 – Adjustment Request Past Filing Limit

Description of Information:

This letter is generated through the online windows. The user enters the provider number or payee and address. The information entered populates the Return to Sender Letter and a copy of the check requesting documentation to waive the filing limit.

Purpose:

To obtain documentation to waive the filing limit

Sort Sequence:

None

Distribution:

To	Media Type	Copies	Frequency
Provider	Paper	1	On request

950 North Meridian Street, STE 1150
Indianapolis, Indiana 46204-4288

(317) 488-5000
Fax: (317) 488-5169

Date

Provider Name
Address
City, State Zip Code

ATTN: Patient Accounts
RE: Cash Control Number

Dear Provider:

The enclosed adjustment request(s) submitted by your office either had no documentation or insufficient documentation to waive the filing limit. State regulations specify that all claims must be submitted within one year of the date of service (*405 IAC 1-1-3 (3)(a)*). This is also applicable to adjustment requests. All adjustments to a paid claim must be submitted within one year of the claim's paid date. If an extenuating circumstance exists, a waiver of the filing limit may be granted when justification is provided to substantiate why a claim or adjustment request could not be filed or refiled within the allowable time frame.

A waiver of the filing limit may be authorized if documentation is provided demonstrating that one of the following circumstances exists:

1. **Retroactive Eligibility:** In cases of retroactive member eligibility, a waiver of the filing limit will be granted if the provider files within one year from the date eligibility was determined. A letter from the Indiana Family and Social Services Administration (IFSSA) stating the date of retroactive eligibility must accompany the adjustment request form.
2. **Previous Submissions:** Reasonable and continuous attempts on the part of the provider to resolve a claim issue must be demonstrated. Any attempt to resolve the claim payment issue must have been made within one year of the previous attempt. Acceptable documentation for a waiver of the filing limit includes the following:
   - Remittance advice (RA)
   - Dated Return to Provider letter from the contractor
   - Dated Adjustment Request Form
   - Dated Inquiry Form
3. **Late Third Party Liability (TPL) Notification:** When a delay in adjustment filing is due to late notification by the primary insurer of its decision to pay, deny, or adjust charges, the filing limit may be waived if documentation is provided to show that reasonable attempts to bill and collect were made within the one year time frame. Dated correspondence with the primary insurance will serve as appropriate documentation.
4. **Retroactive PA:** When claim adjustment filing is delayed due to retroactive PA, a copy of the PA approval may be submitted as documentation to waive the filing limit. A waiver will be granted if the adjustment is filed within one year of the retroactive PA approval date.
5. **Adjustment to Medicare/Medicaid Crossover claim:** If Medicare has made an adjustment to a previously paid claim, a waiver of the filing limit will be granted if a dated copy of the Medicare

Remittance Notice (MRN) showing the adjusted claim is received within one year of the adjusted Medicare payment.

6. **Administrative Delay:** When a delay in the adjustment filing is a result of an administrative delay (such as an enrollment problem), submit a letter from the county office of the Division of Family and Children (DFC), the IFSSA, or the Office of Medicaid Policy and Planning (OMPP) stating the cause of the administrative delay.

   Please return the enclosed Adjustment Request Form and sufficient supporting documentation to waive the filing limit to the following address:

   EDS – Adjustments Department
   P.O. Box 7265
   Indianapolis, IN 46207-7265

   Please refer to *Chapter 10* of the *Indiana Health Coverage Programs Provider Manual* for additional information about this issue.

   If you have any questions about this matter please contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 or visit the IHCP Web site at http://www.indianamedicaid.com/. Thank you for your participation in the Indiana Health Coverage Programs.

   Sincerely,

   Adjustment Analyst
   Adjustment Unit

   Enclosures

RTS Letter # R21 – Invalid or Missing Member ID

Report Definition Information

Part I

***Functional Area*:** Adjustments/Financial

***Report Number*:** FIN-9021-D

***Report Title*:** RTS Letter # R21 – Invalid or Missing Member ID

Description of Information:

This letter is generated through the online windows. The user enters the provider number or payee and address. The information entered populates the Return to Sender Letter and returns with a copy of the check and corresponding documentation requesting more information.

Purpose:

To obtain more information from the provider to process the adjustment request

Sort Sequence:

None

Distribution:

To	Media Type	Copies	Frequency
Provider	Paper	1	On request

950 North Meridian Street, STE 1150
Indianapolis, Indiana 46204-4288

(317) 488-5000
Fax: (317) 488-5169

Date

Provider Name
Address
City, State Zip Code

ATTN: Patient Accounts
RE: Cash Control Number

Dear Provider:

The enclosed adjustment request submitted by your office is being returned. The request submitted has an invalid or missing member identification number. To process this request appropriately, a valid member identification number must be included. Please correct and return this request and all accompanying documentation to:

EDS – Adjustments Department
P.O. Box 7265
Indianapolis, IN 46207-7265

If you have any questions about this matter please contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 or visit the IHCP Web site at http://www.indianamedicaid.com/. Thank you for your participation in the Indiana Health Coverage Programs.

Sincerely,

Adjustment Analyst
Adjustment Unit

Enclosures

RTS Letter # R22 – Detail Information Missing or Invalid

Report Definition Information

Part I

***Functional Area*:** Adjustments/Financial

Report Number: FIN-9022-D

Report Title: RTS Letter # R22 – Detail Information Missing or Invalid

Description of Information:

This letter is generated through the online windows. The user enters the provider number or payee and address. The information entered populates the Return to Sender Letter and returns a copy of the check and corresponding documentation requesting more information.

Purpose:

To obtain more information from the provider to process the adjustment request

Sort Sequence:

None

Distribution:

To	Media Type	Copies	Frequency
Provider	Paper	1	On request

950 North Meridian Street, STE 1150
Indianapolis, Indiana 46204-4288

(317) 488-5000
Fax: (317) 488-5169

Date

Provider Name
Address
City, State Zip Code

ATTN: Patient Accounts
RE: Cash Control Number

Dear Provider:

The enclosed Adjustment Request Form submitted by your office is being returned due to missing or invalid detail information. Please correct the information as stated below:

Field Description	Line No.	Error
Procedure Code		Missing/Invalid
Procedure Modifier		Missing/Invalid
NDC Code		Missing/Invalid
Date(s) of Service		Missing/Invalid
Diagnosis (ICD-9) Code		Missing/Invalid
Quantity/Units of service		Missing/Invalid

Return the corrected Adjustment Request Form and all accompanying documentation to:

EDS – Adjustments Department
P.O. Box 7265
Indianapolis, IN 46207-7265

If you have any questions about this matter please contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 or visit the IHCP Web site at http://www.indianamedicaid.com/. Thank you for your participation in the Indiana Health Coverage Programs.

Sincerely,

Adjustment Analyst
Adjustment Unit
Enclosures

RTS Letter # R23 – Member Deductible 8A Form Required

Report Definition Information

Part I

Functional Area: Adjustments/Financial

Report Number: FIN-9023-D

Report Title: RTS Letter # R23 – Member Deductible 8A Form Required

Description of Information:

This letter is generated through the online windows. The user enters the provider number or payee and address. The information entered populates the Return to Sender Letter and returns a copy of the check and corresponding documentation requesting an *8A* form.

Purpose:

To obtain more information from the provider to process the adjustment request

Sort Sequence:

None

Distribution:

To	Media Type	Copies	Frequency
Provider	Paper	1	On request

950 North Meridian Street, STE 1150
Indianapolis, Indiana 46204-4288

(317) 488-5000
Fax: (317) 488-5169

Date

Provider Name
Address
City, State Zip Code

ATTN: Patient Accounts
RE: Cash Control Number

Dear Provider:

The enclosed adjustment request submitted by your office is being returned. You have requested that the member deductible amount be changed. Please submit a copy of the *FI 008A* Form to indicate spenddown and return the adjustment request for processing to:

EDS – Adjustments Department
P.O. Box 7265
Indianapolis, IN 46207-7265

If you have any questions about this matter please contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 or visit the IHCP Web site at http://www.indianamedicaid.com/. Thank you for your participation in the Indiana Health Coverage Programs.

Sincerely,

Adjustment Analyst
Adjustment Unit

Enclosures

RTS Letter # R24 – Adjustment Submitted For Denied Claim

Report Definition Information

Part I

Functional Area: Adjustments/Financial

Report Number: FIN-9024-D

Report Title: RTS Letter # R24 – Adjustment Submitted For Denied Claim

Description of Information:

This letter is generated through the online windows. The user enters the provider number or payee and address. The information entered populates the Return to Sender Letter and is sent with the documentation received. A system-generated check is sent the following week.

Purpose:

To inform the payee that the requested claim cannot be adjusted because it was denied.

Sort Sequence:

None

Distribution:

To	Media Type	Copies	Frequency
Provider	Paper	1	On request

950 North Meridian Street, STE 1150
Indianapolis, Indiana 46204-4288

(317) 488-5000
Fax: (317) 488-5169

Date

Provider Name
Address
City, State Zip Code

ATTN: Patient Accounts
RE: Cash Control Number

Dear Provider:

The enclosed adjustment request submitted by your office is being returned. The claim has been denied; therefore, it cannot be adjusted. Please see *Chapter* 8 of the *Indiana Health Coverage Programs Provider Manual*, for procedures for submitting claims.

If you have any questions about this matter please contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 or visit the IHCP Web site at http://www.indianamedicaid.com/. Thank you for your participation in the Indiana Health Coverage Programs.

Sincerely,

Adjustment Analyst
Adjustment Unit

Enclosures

RTS Letter # R25 – Claim Paid According to Regulations

Report Definition Information

Part I

Functional Area: Adjustments/Financial

Report Number: FIN-9025-D

Report Title: RTS Letter # R25 – Claim Paid According to Regulations

Description of Information:

This letter is generated through the online windows. The user enters the provider number or payee and address. The information entered populates the Return to Sender Letter and is sent with the documentation received. A system-generated check is sent the following week.

Purpose:

To inform the payee that an adjustment requested is not needed because the claim was correctly paid.

Sort Sequence:

None

Distribution:

To	Media Type	Copies	Frequency
Provider	Paper	1	On request

950 North Meridian Street, STE 1150
Indianapolis, Indiana 46204-4288

(317) 488-5000
Fax: (317) 488-5169

Date

Provider Name
Address
City, State Zip Code

ATTN: Patient Accounts
RE: Cash Control Number

Dear Provider:

The enclosed adjustment request submitted by your office is being returned. Records indicate that this claim has been paid according to Indiana Health Coverage Programs policy guidelines. Please review the claim and make the appropriate corrections, if any, and resubmit them to the following address if an adjustment is still required:

EDS – Adjustments Department
P.O. Box 7265
Indianapolis, IN 46207-7265

If you have any questions about this matter please contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 or visit the IHCP Web site at http://www.indianamedicaid.com/. Thank you for your participation in the Indiana Health Coverage Programs.

Sincerely,

Adjustment Analyst
Adjustment Unit

Enclosures

RTS Letter # R99 – Miscellaneous/Unspecified

Report Definition Information

Part I

Functional Area: Adjustments/Financial

Report Number: FIN-9099-D

Report Title: RTS Letter # R99 – Miscellaneous/Unspecified

Description of Information:

This letter is generated through the online windows. The user enters the provider number or payee and address. The information entered populates the Return to Sender Letter and returns with a copy of the check and corresponding documentation requesting more information.

Purpose:

To obtain more information from the provider about the nature of the requested claim review to process the adjustment request.

Sort Sequence:

None

Distribution:

To	Media Type	Copies	Frequency
Provider	Paper	1	On request

950 North Meridian Street, STE 1150
Indianapolis, Indiana 46204-4288

(317) 488-5000
Fax: (317) 488-5169

Date

Provider Name
Address
City, State Zip Code

ATTN:
RE:

Dear:

{Body of letter to be written in comments section}

If you have any questions about this matter please contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 or visit the IHCP Web site at http://www.indianamedicaid.com/. Thank you for your participation in the Indiana Health Coverage Programs.

Sincerely,

Adjustment/Finance Analyst
Adjustment/Finance Unit

Enclosures

Appendix A: Adjustment Work Flow

Noncheck-Related Adjustments Processing

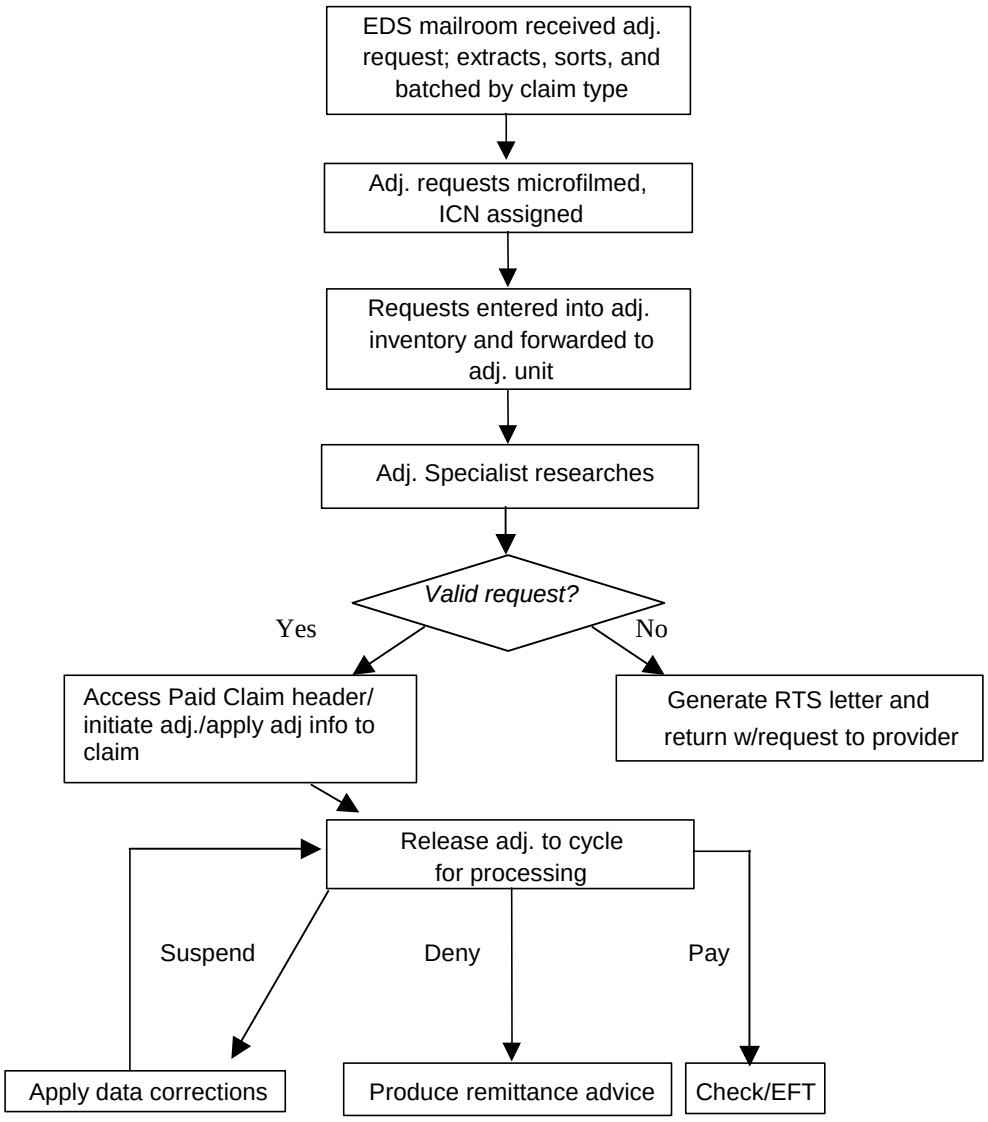


Figure A.1 – Noncheck-Related Adjustment Processing

Expenditure Payout (System and Manual)

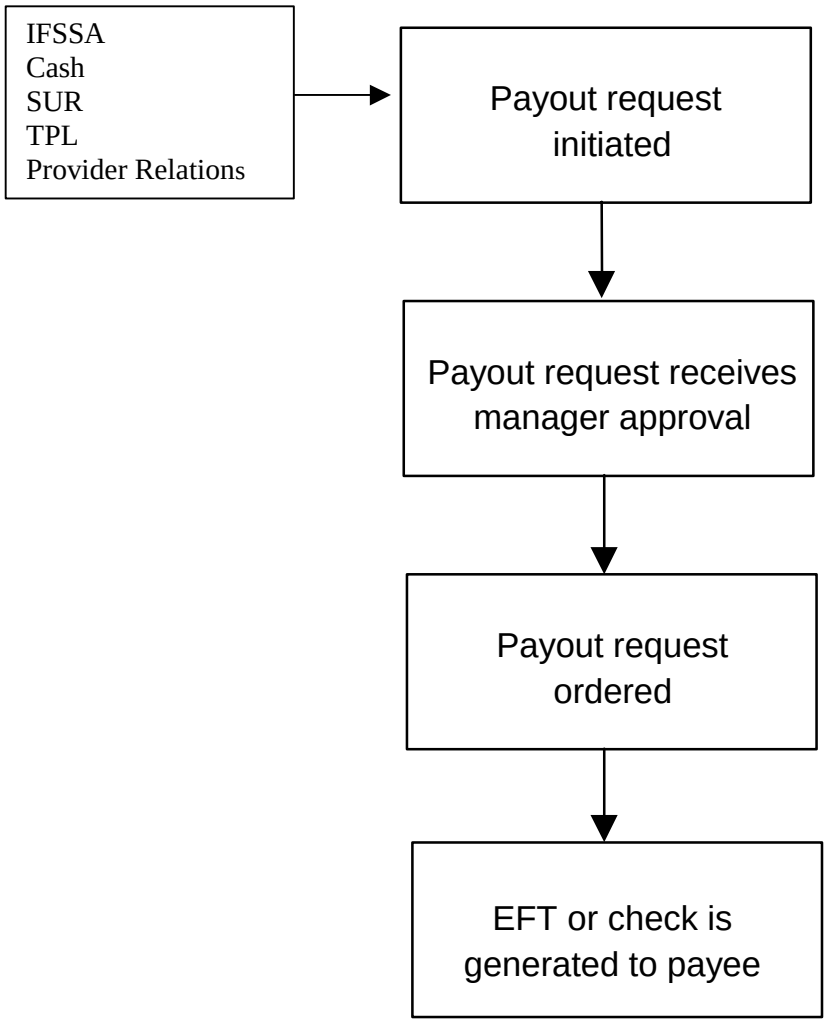


Figure A.2 – Expenditure Payout – System and Manual

Check-related Adjustment Processing

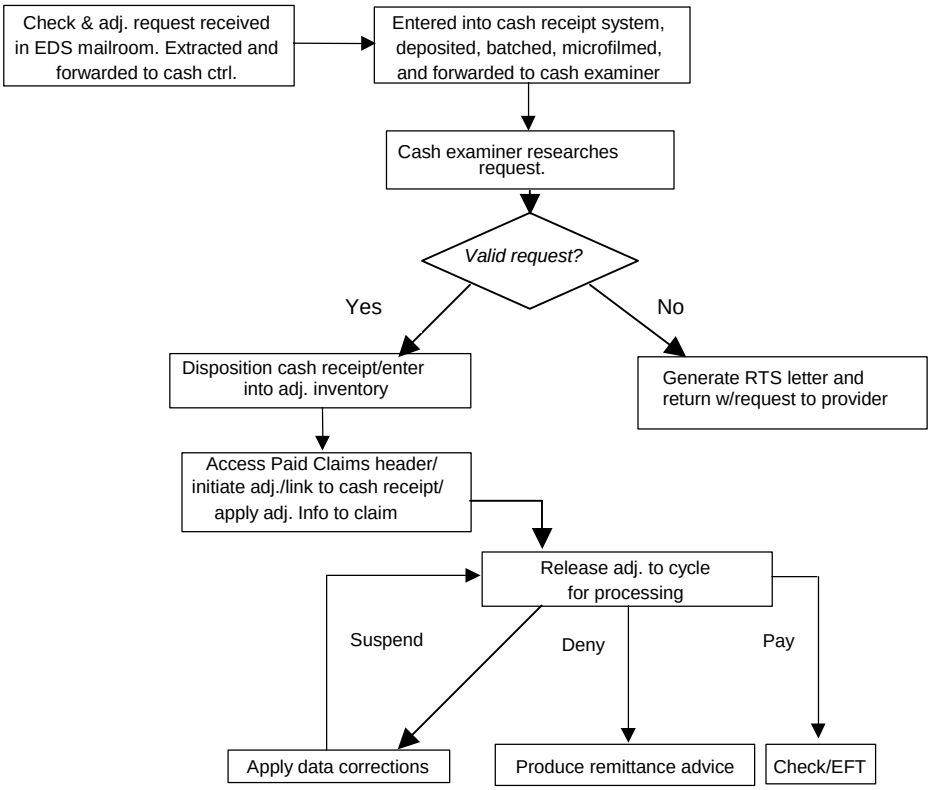


Figure A.3 – Check-related Adjustment Processing

Expenditure Flow Chart

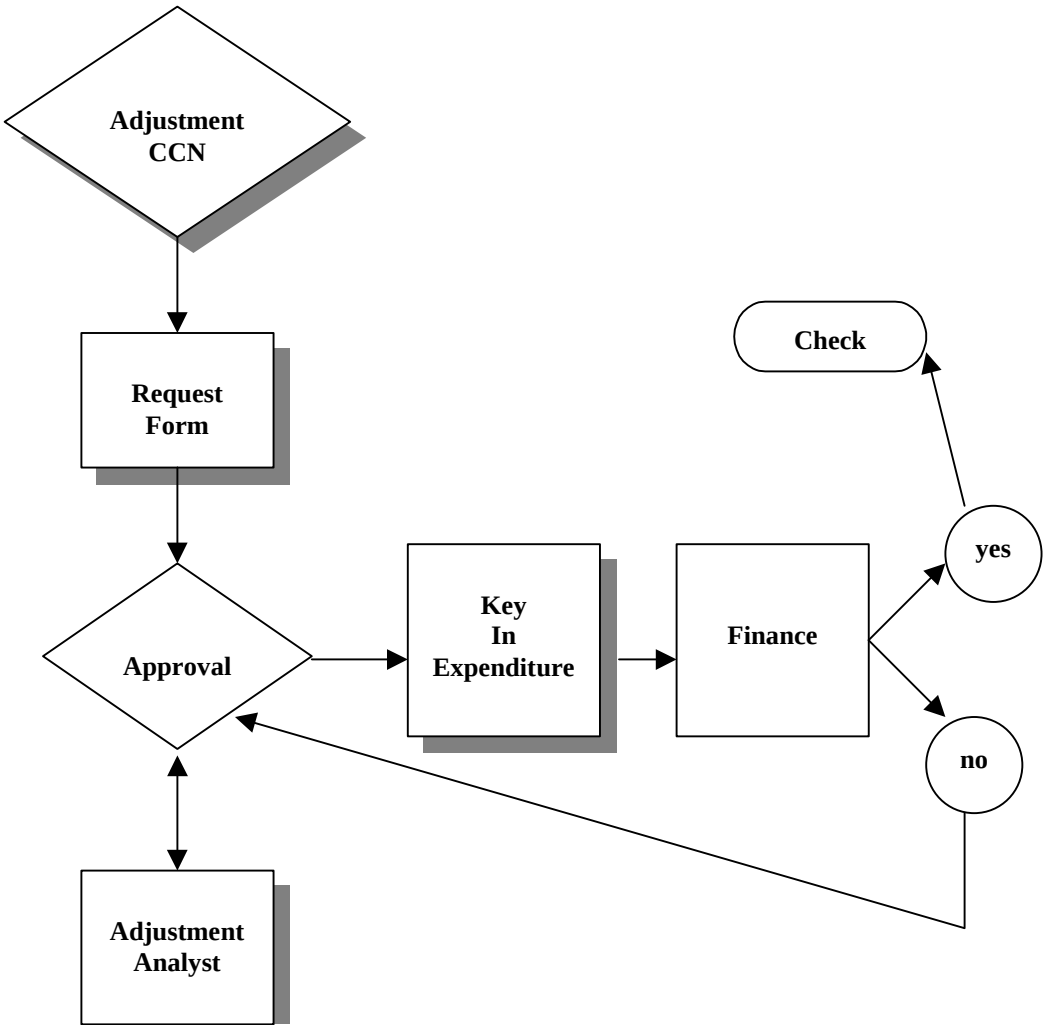


Figure A.4 – Expenditure Flow Chart

Accounts Receivable Setup/Maintenance

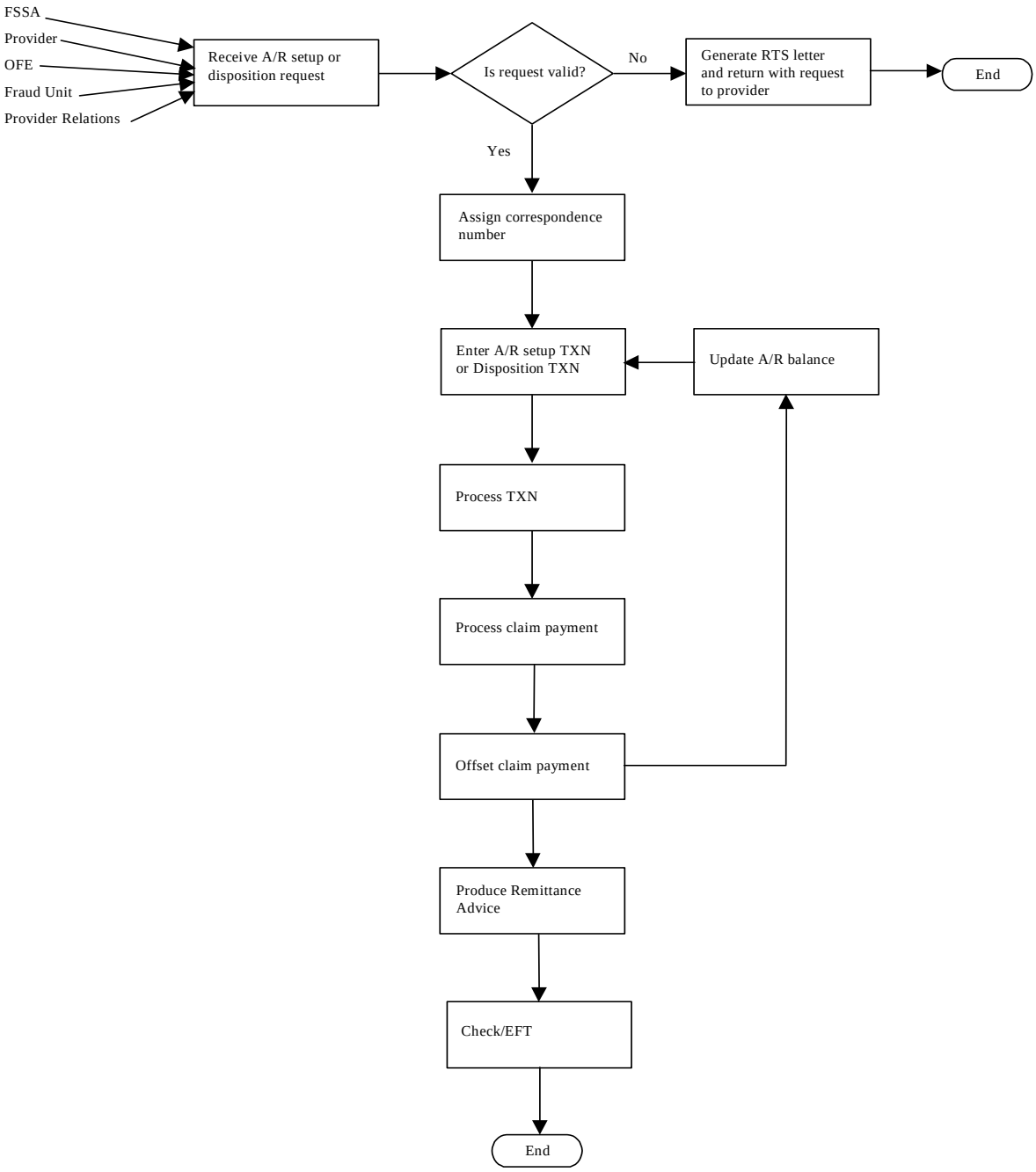


Figure A.5 – Accounts Receivable Setup/Maintenance

Nonclaim-specific Provider Refund

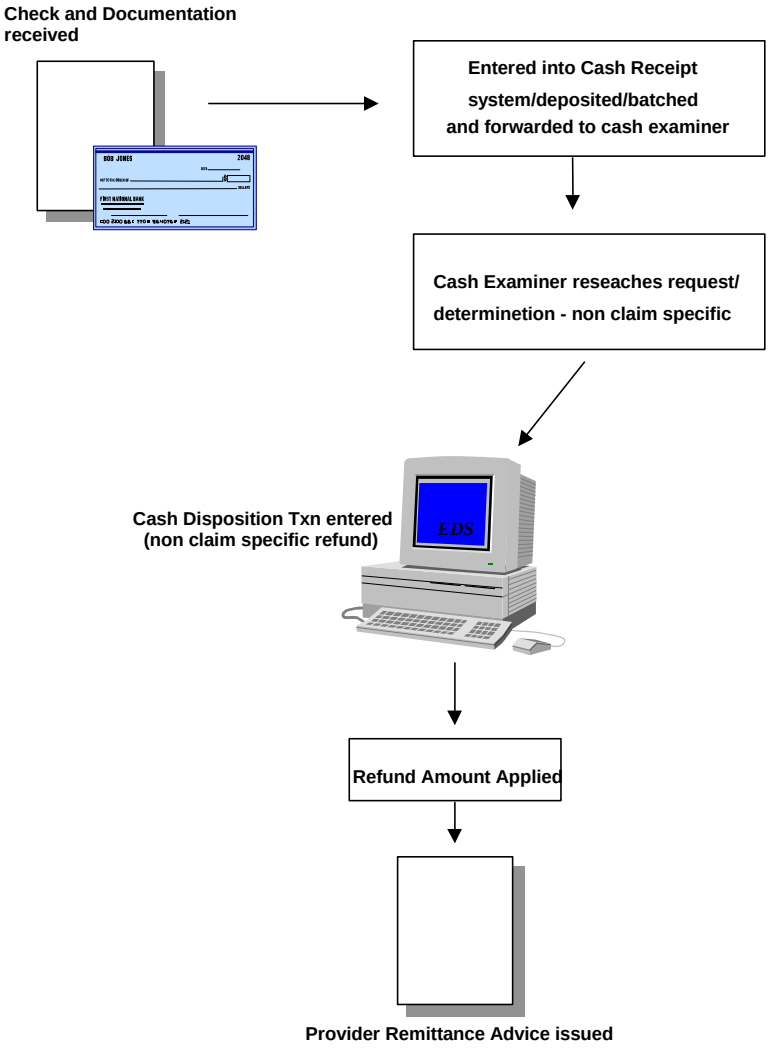


Figure A.6 – Nonclaim-specific Provider Refund

Check-related Spenddown

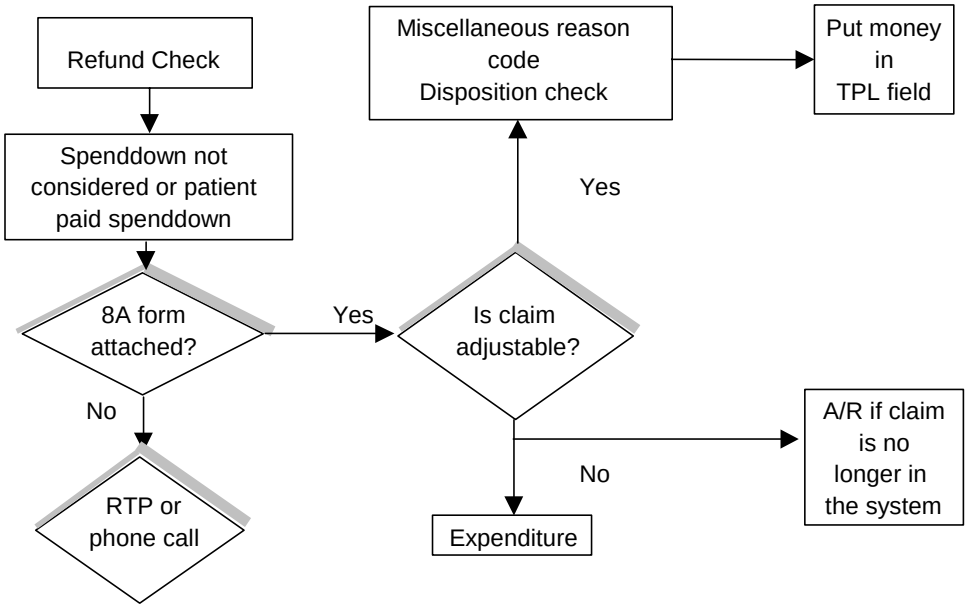


Figure A.7 – Check-related Spenddown

Training Flow – Noncheck-related

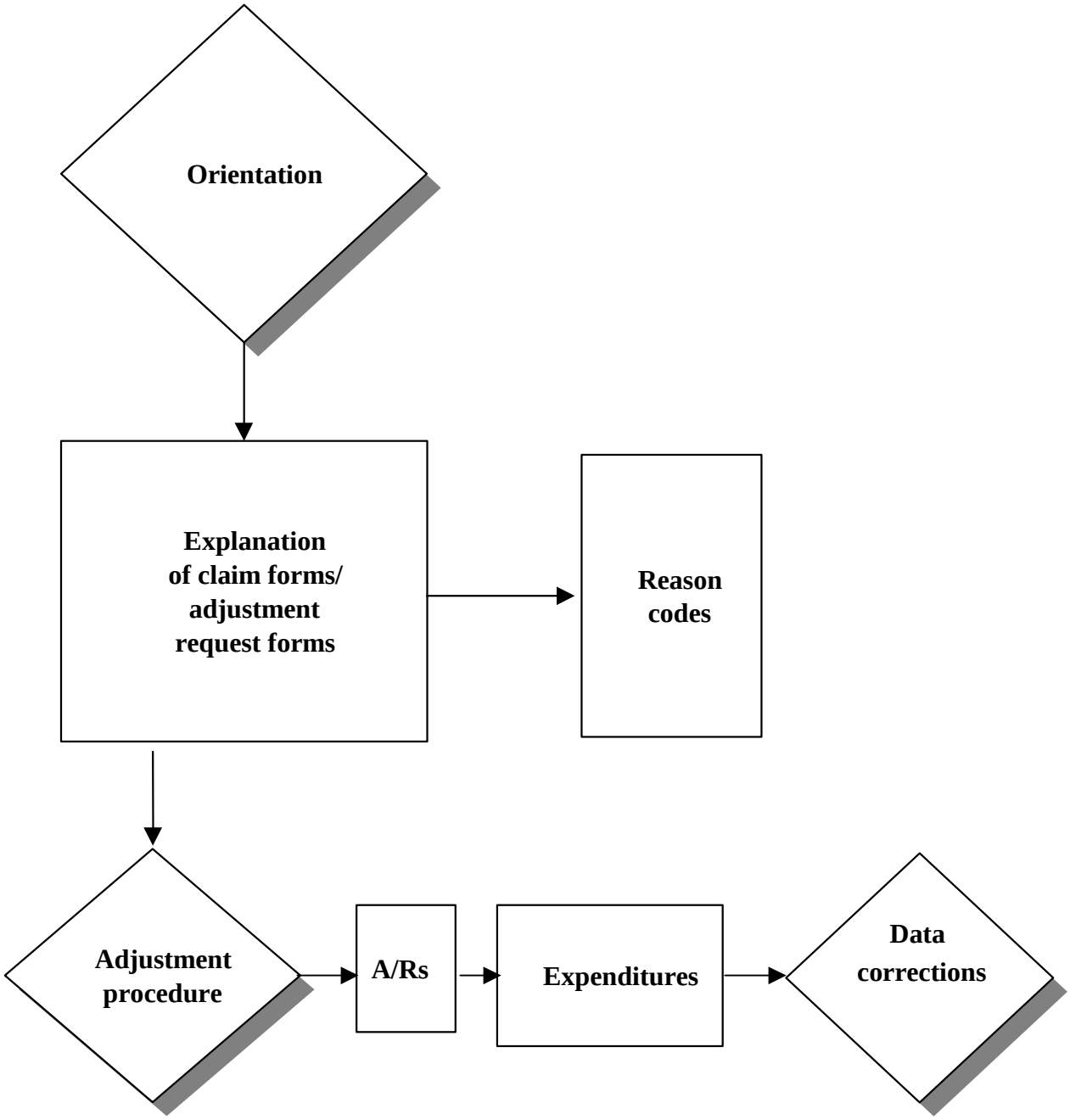


Figure A.8 – Training Flow – Noncheck-related

Workflow

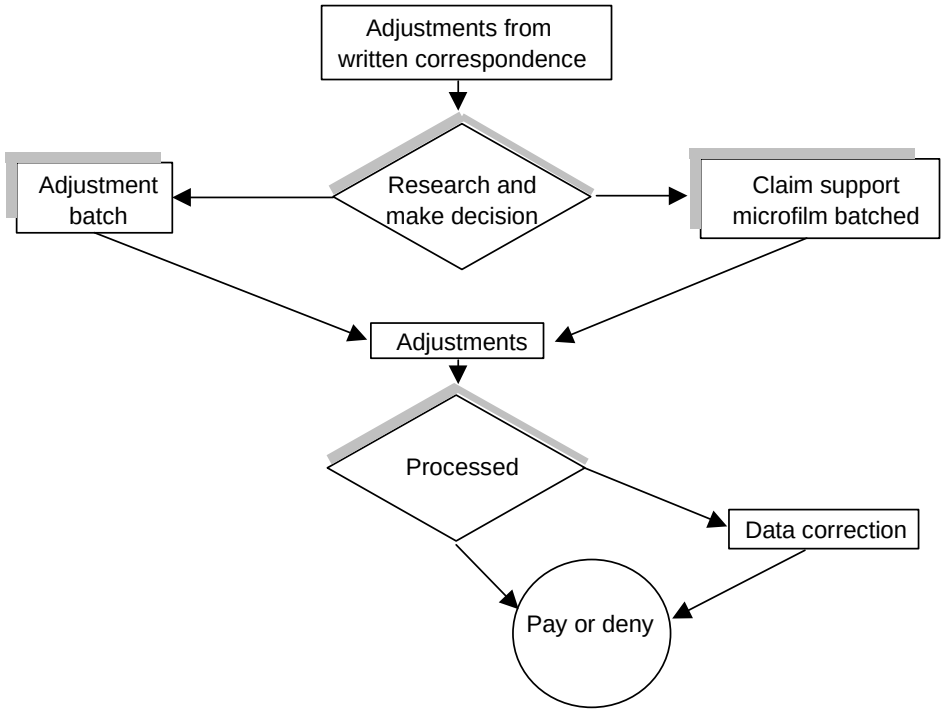


Table A.9 – Workflow

Noncheck-related Workflow

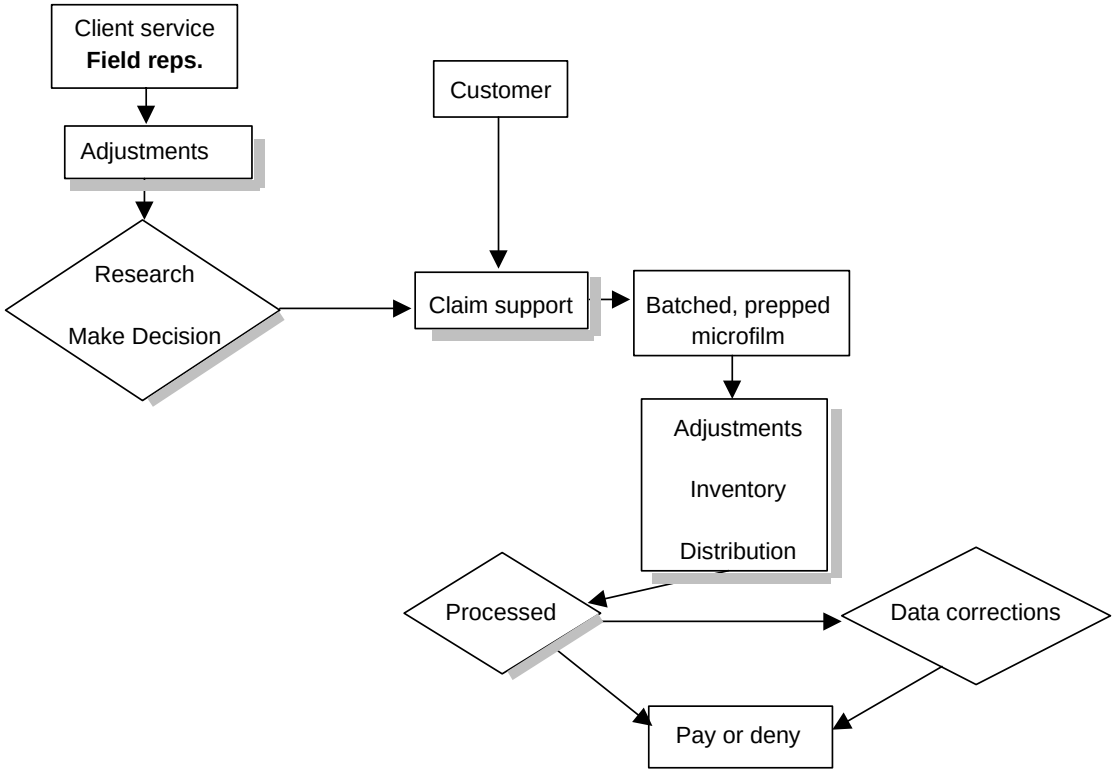


Figure A.10 – Noncheck-related Workflow

Adjustments for SUR Edits

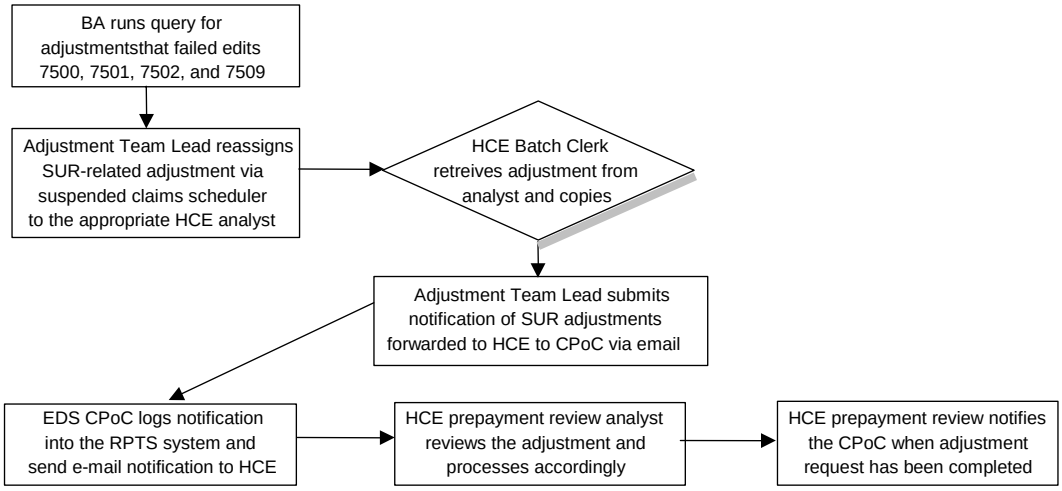


Figure A.11 – Adjustments for SUR Edits

Check-related Flowchart

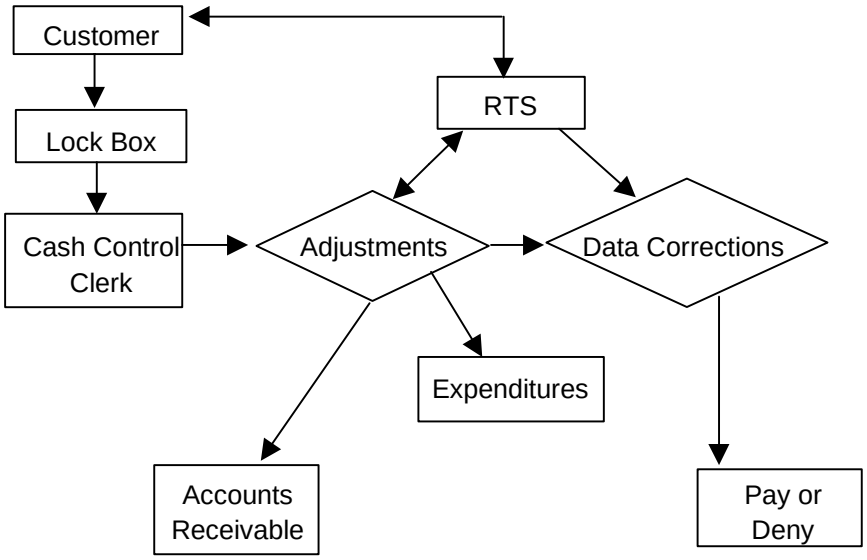


Figure A.12 – Check-related Flowchart

Appendix B: Sample Forms

The following pages illustrate forms that are used when working with adjustments.

Indiana Health Coverage Programs

EDS **B A T C H H E A D E R S H E E T**

Total Count	**Julian Date**	**Claim Type**		**Batch Number**
Beginning Seq. Number	**Ending Seq. Number**	**Singles**	**Attachments**	
Prepper ID	**Microfilmer**			

Void Reasons:
a. Invalid provider number
b. Missing provider number
c. Missing location code
d. Attachment in crossover
e. Crossover in attachment batch
f. Invalid EOMB
g. Invalid type of bill
h. Missing type of bill
i. Other (reason indicated below)

Data Entry Batch Prepper _____ **Date** _____

Data Entry Operator _____ **Date** _____

Resuming Data Entry Operator _____ **Date** _____

Quality Analyst _____

Date _____

Seq Number/Void Reason	Seq Number/Void Reason	Seq Number/Void Reason	Seq Number/Void Reason
0	25	50	75
1	26	51	76
2	27	52	77
3	28	53	78
4	29	54	79
5	30	55	80
6	31	56	81
7	32	57	82
8	33	58	83
9	34	59	84
10	35	60	85
11	36	61	86
12	37	62	87
13	38	63	88
14	39	64	89
15	40	65	90
16	41	66	91
17	42	67	92
18	43	68	93
19	44	69	94
20	45	70	95
21	46	71	96
22	47	72	97
23	48	73	98
24	49	74	99

Figure B.1 – Batch Header Sheet

INSTITUTIONAL
MEDICARE / MEDICAID CROSSOVER

"x" appropriate box:
INPATIENT/LONG TERM CARE ☐
OUTPATIENT/HOME HEALTH ☐

1 PATIENT CONTROL NO.	2 TYPE OF BILL

STATEMENT COVERS PERIOD	
3a FROM	3b THROUGH

Detail: **(Inpatient / LTC Crossovers Only)**

4 REV 001 TOTAL CHARGE	5 BASE REV CODE	6 UNITS
$		

Details: **(Outpatient/Home Health Crossovers Only)**

Detail Number	7 REV CODE	8 HCPCS	9 MODIFIERS			10 SERVICE DATE	11 SERVICE UNITS	12 TOTAL CHARGES	Detail Number
1								$	1
2								$	2
3								$	3
4								$	4
5								$	5
6								$	6
7								$	7
8								$	8
9								$	9
10								$	10
11								$	11
12								$	12

Payer	Other Insurance		Prior Payments	
A	13a	*MEDICARE*	13b	$
B – TPL	14a		14b	$

	15a Medicaid Billing Provider Number	15b Loc. Code	15c Prior Payment	15d Estimate Amount Due
C - Medicaid			$	$

16a Patient's Last Name	16b First Name	16c RID Number

17 Principal Diagnosis Code (5-digit field)

18 Signature	19 Bill Date

Medicare EOMB Data:

20a Deductible Amount	20b Co-Insurance Amount	20c Blood Deductible Amount
$	$	$

Figure B.2 – UB-92/Crossover Part A and C Adjustment Request

INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION

UB-92 AND INPATIENT/OUTPATIENT CROSSOVER ADJUSTMENT REQUEST

Mail completed requests to: EDS - Adjustments, P.O. Box 7265, Indianapolis, IN 46207-7265

(1) PROVIDER NUMBER: **PROVIDER NAME/ADDRESS:** **PHONE NUMBER:** **CONTACT PERSON:**	**(2) REASON FOR ADJUSTMENT:** **(Check appropriate Box)** ☐ **Change TPL Amt.** ☐ **Change Patient Deductible Amt.** ☐ **Offset or Refund of entire claim amount (please check block 10)** ☐ **Change information as indicated in blocks 13-16** ☐ **Medicare Adjustment (Attach all EOMBs that apply to this adjustment)**

(3) CLAIM NUMBER (ICN)	**(4) RECIPIENT ID NO.**	**(5) DATE OF SERVICE** **From** **Thru**
(6) RECIPIENT NAME	**(7) AMOUNT PAID**	**(8) REMITTANCE ADVICE DATE**

(9) TYPE OF ADJUSTMENT	**(10) CLAIM TYPE**	**(11) PROGRAM**
☐ **Underpayment Adjustment**	☐ **Inpatient**	☐ **Medicaid**
☐ **Overpayment Adjustment (Deduct from future payments)**	☐ **Outpatient**	☐ **CSHCS**
☐ **Refund Adjustment (Check attached)**	☐ **Long Term Care**	☐ **ARCH**
Check number:	☐ **Home Health**	☐ **590**
	☐ **Crossover**	

(12) GIVE COMPLETE EXPLANATION OF ADJUSTMENT OR REFUND REQUEST:

PLEASE LIST THE INFORMATION TO BE CORRECTED IN THE BLOCKS BELOW. IF NO LINE NO. IS ASSOCIATED WITH THE CORRECTION, PLEASE ENTER A ZERO (0) IN THE LINE NUMBER FIELD. (i.e. TPL APPLIED WOULD ALWAYS BE LINE # 0.)

(13)	**(14)**	**(15)**	**(16)**
REV/PROC CODE.	**DESCRIPTION OF INFORMATION TO BE CORRECTED**	**CURRENT INFORMATION**	**CORRECTED INFORMATION**

(17) SIGNATURE: _____ **(18) DATE:**

Figure B.3 – UB-92 and Inpatient/Outpatient Crossover Adjustment Request Form

HCFA- 1500, DENTAL, CROSSOVER PART B PAID CLAIM ADJUSTMENT REQUEST

INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION

Mail completed requests to: EDS - Adjustments, P.O. Box 7265, Indianapolis, IN 46207-7265

(1) PROVIDER NUMBER:	**(2) REASON FOR ADJUSTMENT:** (Check appropriate Box)
PROVIDER NAME/ADDRESS:	·☐ Change TPL Amt. ☐ Change Patient Deductible Amt. ·☐ Offset or Refund of entire claim amount (please check block 10)
PHONE NUMBER	☐ Change information as indicated in blocks 13-16
CONTACT PERSON:	☐ Medicare Adjustment (Attach all EOMBs that apply to this adjustment)

(3) CLAIM NUMBER (ICN)	**(4) RECIPIENT ID NO.**	**(5) DATE OF SERVICE** From Thru
(6) RECIPIENT NAME	**(7) AMOUNT PAID**	**(8) REMITTANCE ADVICE DATE**

(9) GIVE COMPLETE EXPLANATION OF ADJUSTMENT OR REFUND REQUEST:

(10) TYPE OF ADJUSTMENT	**(11) CLAIM TYPE**	**(12) PROGRAM**
☐ Underpayment Adjustment	☐ HCFA-1500	☐ Medicaid
☐ Overpayment Adjustment (Deduct from future payments)	☐ Dental	☐ CSHCS
☐ Refund Adjustment (Check attached)	☐ Crossover	☐ ARCH
Check number:		☐ 590

PLEASE LIST THE INFORMATION TO BE CORRECTED IN THE BLOCKS BELOW. IF NO LINE NO. IS ASSOCIATED WITH THE CORRECTION, PLEASE ENTER A ZERO (0) IN THE LINE NUMBER FIELD. (i.e. TPL APPLIED WOULD ALWAYS BE LINE # 0.)

(13) LINE NO.	**(14) DESCRIPTION OF INFORMATION TO BE CORRECTED**	**(15) CURRENT INFORMATION**	**(16) CORRECTED INFORMATION**

(17) SIGNATURE: _____ **(18) DATE:**

Figure B.4 – CMS-1500, Dental, Crossover Part B Paid Claim Adjustment Request Form

Indiana Health Coverage Programs

I N D I A N A F A M I L Y A N D S O C I A L S E R V I C E S A D M I N I S T R A T I O N
P H A R M A C Y P A I D C L A I M A D J U S T M E N T R E Q U E S T

List no more than 10 claims per request.

(1) Provider Number:

Provider Name/Address:

Phone Number: ( ) -

Contact Person:

Mail completed adjustment request forms to the following address:
EDS – Adjustments/Finance Department
P. O. Box 7265
Indianapolis, IN 46207-7265

(2) Program
- ☐ Medical
- ☐ 590
- ☐ CSHCS
- ☐ Arch

(3) Type Of Adjustment
- ☐ Underpayment Adjustment
- ☐ Overpayment Adjustment (Deduct from future payments)
- ☐ Refund Adjustment (Check attached)

Check number:

Complete blocks 4 – 10 for each pharmacy claim to be adjusted. If all information is not complete, this request will be returned.

(4) Claim Number	(5) Member ID	(6) Dispense Date	(7) Amount Paid	(8) Current Information	(9) Corrected Information	(10) Explanation Of Adjustment

(11) Signature:

(12) Date:

Figure B.5 – Pharmacy Adjustment Request Form

Phone Log

PHONE LOG	
Provider Name:	**Phone #:**
Contact Person:	**Date:**
Time:	**Reason:**
Q:	
A:	
Q:	
A:	
Q:	
A:	
Q:	
A:	
Q:	
A:	
Q:	
A:	
EDS Personnel Signature _____	

Figure B.6 – Phone Log

Open Claim Log

OPEN CLAIM LOG	
ICN #:	**Date Opened**
CCN #:	
Provider Name:	
Contact Person:	
EDS Personnel:	

Date: _____	
Action Taken:	
Date: _____	
Action Taken:	
Date: _____	
Action Taken:	
Date: _____	
Action Taken:	
Date: _____	
Action Taken:	

Figure B.7 – Open Claim Log

Expenditure Payout Request

Expenditure Number _____

Submitted by: _____ Date: _____

Payee's Name: _____ PROVIDER or PAYEE'S # _____

Address: _____

City/State/Zip: _____

Attn: _____ Payout Amount: $ _____

CCN:_____ Check#:_____ Check Amount: $ _____

Circle One: Manual Check System Check

Justification (attach all supporting documentation): _____

_____

_____

_____

_____

Approval Signature: _____ Date: _____

Expenditure Keyed By:_____ Date: _____

Disapproval Reason: _____

_____

Expenditure Check List (Must be completed):	
Copy of refund check being returned _____	Screen prints of affected claims _____
Copy of adjustment information _____	Detailed reason for expenditure _____
Copy of adjustment phone log _____	Searched for duplicate claims _____
No Open accounts receivable _____	
Finance Use Only:	
Activated By: _____	Manual Check Number: _____
Date Activated: _____	Manual Check Issue Date: _____
State Letter Number _____	Accounts Receivable # _____

Figure B.8 – Expenditure Payout Request

Noncheck Adjustments Production Sheet

Name: _____
Date: _____
Time Worked: _____

Batch Number (list any batches that were deleted)	# claims deleted out of batch	# A/R's / Expend / RTS	RX	Dental	Medical	Inpt	Outpt	LTC	Home Health	UB Xover	Med Xover	Batch Done Y/N
1.												
2.												
3.												
4.												
5.												
6.												
7.												
8.												
9.												
10.												
11.												
12.												
Data Corrections												
TOTAL												

Figure B.9 – Noncheck Adjustments Production Sheet

Provider Accounts Receivable
(INTERNAL)

Submitted By:_____**Date:**_____

Provider Name:_____

Provider Number:_____**Location**:_____

SETUP REQUEST

PROG.CODE: MEDICAID 590 ARCH CSHCS

REASON FOR SETUP:

SETUP AMOUNT: _____ NUMBER OF ADJUSTMENTS: _____

DATES OF SERVICE:_____

TO BE FILLED OUT BY ACCOUNTS RECEIVABLE CLERK

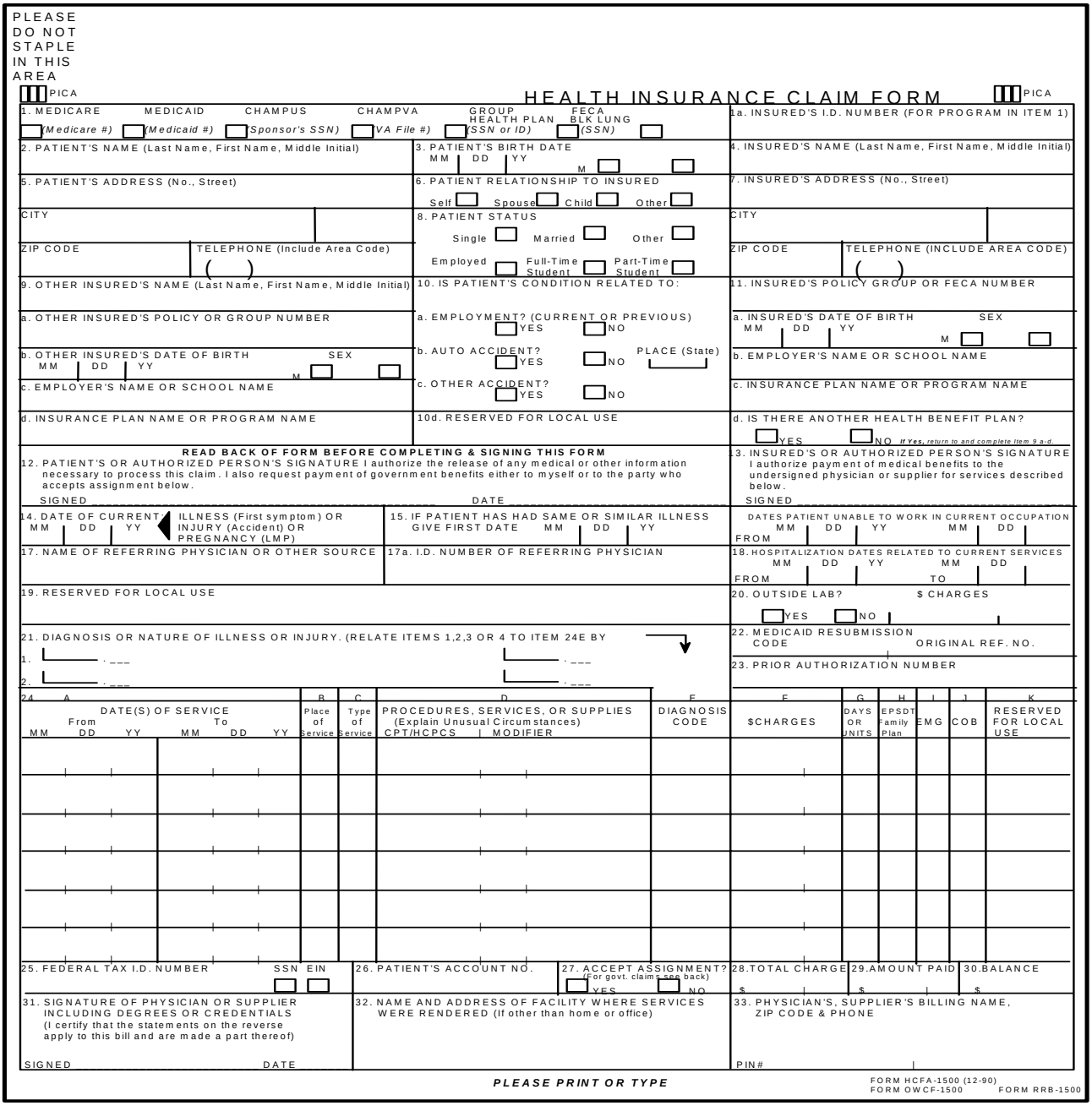
DATE ENTERED:_____

ASSIGNED A/R NUMBER:_____

ASSIGNED CCN NUMBER:_____

Figure B.10 – Provider Accounts Receivable

Health Insurance Claim Form



PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If Yes, return to and complete Item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY MM DD FROM

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY

1. . ___

2. . ___

. ___

. ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ZIP CODE & PHONE

PIN#

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCF-1500 FORM RRB-1500

Figure B.11 – Health Insurance Claim Form

Check-Related Adjustments Production Sheet

Name: _____

Date: _____

Time Worked: _____

BATCH NUMBER	# CKS IN BATCH	# CKS DONE IN BATCH	# CLMS DONE	# A/R / EXPEND	# RTS LETTERS SENT	BATCH DONE Y/N
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
Data Corrections						
TOTAL						

Figure B.12 – Check-Related Adjustments Production Sheet

Appendix C: Adjustment Reason Codes

Table C.1 – Adjustment Reason Codes

Code	Description
8000	Provider initiated full claim offset – duplicate payment
8001	Provider initiated full claim offset – wrong provider paid
8002	Provider initiated full claim offset – wrong recipient number
8003	Provider initiated full claim offset – wrong drug/procedure/modifier code
8004	Provider initiated full claim offset – wrong units of service
8005	Provider initiated full claim offset – wrong patient liability amount
8006	Provider initiated full claim offset – TPL (other health insurance) related
8007	Provider initiated full claim offset – TPL Medicare related
8008	Provider initiated full claim offset – wrong service date(s)
8009-8018	**Reserved for future use**
8019	Provider initiated full claim offset – misc. or unspecified error
8020	EDS initiated full claim offset – duplicate payment
8021	EDS initiated full claim offset – wrong provider paid
8022	EDS initiated full claim offset – wrong recipient number
8023	EDS initiated full claim offset – wrong drug/procedure/modifier code
8024	EDS initiated full claim offset – wrong units of service
8025	EDS initiated full claim offset – wrong patient liability amount
8026	EDS initiated full claim offset – TPL (other health insurance) related
8027	EDS initiated full claim offset – TPL Medicare-related
8028	EDS initiated full claim offset – wrong service date(s)
8029-8038	**Reserved for future use**
8039	EDS initiated full claim offset – misc. or unspecified error
8040	Provider initiated full claim refund – duplicate payment
8041	Provider initiated full claim refund – wrong provider paid
8042	Provider initiated full claim refund – wrong recipient number
8043	Provider initiated full claim refund – wrong drug/procedure/modifier code
8044	Provider initiated full claim refund – wrong units of service
8045	Provider initiated full claim refund – TPL (other insurance) related
8046	Provider initiated full claim refund – TPL Medicare-related
8047	Provider initiated full claim refund – wrong service date(s)
8048-8058	**Reserved for future use**

(Continued)

Table C.1 – Adjustment Reason Codes

Code	Description
8059	EDS/Provider initiated full claim refund – misc. or unspecified error
8060	Meyers & Stauffers requested full claim refund – duplicate payment
8061	ACS requested full claim refund – wrong provider paid
8062	HCE/SUR requested full claim refund – wrong recipient number
8063	HCE/SUR requested full claim refund – wrong drug/procedure/modifier
8064	HCE/SUR requested full claim refund – wrong units of service
8065	HCE/SUR requested full claim refund – TPL (other health insurance) related
8066	HCE/SUR requested full claim refund – TPL Medicare-related
8067	HCE/SUR requested full claim refund – wrong service date(s)
8068	EDS requested a full refund due to wrong patient liability amount
8069	HCE/SUR requested a full refund date due to wrong charge billed
8070 -8078	**Reserved for future use**
8079	EDS requested full claim refund – misc. or unspecified
8080	Provider initiated underpayment adjustment – wrong recipient number
8081	Provider initiated underpayment adjustment – wrong drug/procedure/modifier code
8082	Provider initiated underpayment adjustment – wrong units of service
8083	Provider initiated underpayment adjustment – wrong drug/procedure/modifier code
8084	Provider initiated underpayment adjustment – wrong units of service
8085	Provider initiated underpayment adjustment – wrong patient liability amount
8086	Provider initiated underpayment adjustment – TPL (other health insurance) related
8087	Provider initiated underpayment adjustment – TPL Medicare-related
8088	Provider initiated underpayment adjustment – wrong submitted charge
8089-8098	**Reserved for future use**
8099	Provider initiated underpayment adjustment – misc. or unspecified error
8100	EDS initiated underpayment adjustment – wrong recipient number
8101	EDS initiated underpayment adjustment – wrong drug/procedure/modifier
8102	EDS initiated underpayment adjustment – wrong units of service
8103	EDS initiated underpayment adjustment – wrong patient liability amount
8104	EDS initiated underpayment adjustment – wrong submitted charge
8105	EDS initiated underpayment adjustment – wrong service dates
8106	EDS initiated underpayment adjustment – TPL (other health insurance) related
8107	EDS initiated underpayment adjustment – TPL Medicare-related

(Continued)

Table C.1 – Adjustment Reason Codes

Code	Description
8108-8118	**Reserved for future use**
8119	EDS initiated underpayment adjustment – misc. or unspecified error
8120	Provider initiated overpayment offset adjustment – duplicate payment
8121	Provider initiated overpayment offset adjustment – wrong drug/procedure/modifier code
8122	Provider initiated overpayment offset adjustment – wrong units of service
8123	Provider initiated overpayment offset adjustment – wrong patient liability amount
8124	Provider initiated overpayment offset adjustment – TPL (other health insurance) related
8125	Provider initiated overpayment offset adjustment – TPL Medicare-related
8126	Provider initiated overpayment offset adjustment – wrong service date(s)
8127-8138	Reserved for future use
8139	Provider initiated overpayment offset adjustment – misc. or unspecified error
8140	EDS initiated overpayment offset adjustment – duplicate payment
8141	EDS initiated overpayment offset adjustment – wrong drug/procedure/modifier
8142	EDS initiated overpayment offset adjustment – wrong units of service
8143	EDS initiated overpayment offset adjustment – wrong patient liability amount
8144	EDS initiated overpayment offset adjustment – TPL (other health insurance) related
8145	EDS initiated overpayment offset adjustment – TPL Medicare-related
8146	EDS initiated overpayment offset adjustment – wrong service date(s)
8147-8158	**Reserved for future use**
8159	EDS initiated overpayment offset adjustment – misc. or unspecified error
8160	Provider initiated overpayment refund adjustment – duplicate payment
8161	Provider initiated overpayment refund adjustment – wrong drug/procedure/modifier
8162	Provider initiated overpayment refund adjustment – wrong units of service
8163	Provider initiated overpayment refund adjustment – wrong patient liability amount
8164	Provider initiated overpayment refund adjustment – TPL (other health insurance) related
8165	Provider initiated overpayment refund adjustment – TPL Medicare-related
8166	Provider initiated overpayment refund adjustment – wrong service date(s)
8167	Provider initiated overpayment refund adjustment – wrong submitted charge

(Continued)

Table C.1 – Adjustment Reason Codes

Code	Description
8168-8178	**Reserved for future use**
8179	Provider initiated overpayment refund adjustment – misc. or unspecified
8180	SUR requested overpayment refund adjustment – duplicate payment
8181	SUR requested overpayment refund adjustment – wrong drug/procedure/modifier
8182	SUR requested overpayment refund adjustment – wrong units of service
8183	SUR requested overpayment refund adjustment – wrong patient liability amount
8184	SUR requested overpayment refund adjustment – TPL (other health insurance) related
8185	SUR requested overpayment refund adjustment – TPL Medicare-related
8186	SUR requested overpayment refund adjustment – wrong service date(s)
8187-8198	**Reserved for future use**
8199	SUR requested overpayment refund adjustment – misc. or unspecified
8200	SUR initiated full claim offset
8201	SUR requested full claim offset
8202	SUR initiated overpayment offset adjustment
8203	SUR requested overpayment offset adjustment
8204-8210	**Reserved for future SUR use**
8211-8219	**Reserved for future use**

Appendix D: Accounts Receivable Batch Ranges

Table D.1 – Accounts Receivable Batch Ranges

Number	Description
950-954	A/R – manual setup (misc.)
960-964	A/R – manual setup (SUR)
970-974	A/R – manual setup (Fraud)
980-984	A/R – manual setup (OFE)
990-994	A/R – manual setup (Partial Payment)

Appendix E: Accounts Receivable Disposition Reason Codes

Table E.1 – Accounts Receivable Disposition Reason Codes

Code	Description
8430	A/R increase – State directed
8431	A/R increase – interest applied
8432	A/R increase SUR directed
8433	A/R increase – misc.
8434	A/R decrease – State directed
8435	A/R decrease – SUR directed
8436	A/R decrease – cash receipt applied to principal
8437	A/R decrease – provider over-refund applied
8438	A/R decrease liquidating A/R
8439	A/R decrease – misc.
8440	A/R write-off
8441	A/R decrease – cash receipt applied to interest
8442-8444	**Reserved for future use**
8445	A/R decrease – established for wrong provider
8446	A/R decrease – stop paid system check applied
8447-8499	**Reserved for future use**

Appendix F:Cash Disposition Reason Codes

Table F.1 – Cash Disposition Reason Codes

Code	Description
8040	Provider initiated full claim refund – duplicate payment
8041	Provider initiated full claim refund – wrong provider paid
8042	Provider initiated full claim refund – wrong recipient number
8043	Provider initiated full claim refund – wrong drug/procedure/modifier code
8044	Provider initiated full claim refund – wrong units of service
8045	Provider initiated full claim refund – TPL (other insurance) related
8046	Provider initiated full claim refund – TPL Medicare-related
8047	Provider initiated full claim refund – wrong service date(s)
8048-8058	**Reserved for future use**
8059	EDS/Provider initiated full claim refund – misc. or unspecified error
8060	Meyers & Stauffers requested full claim refund – duplicate payment
8061	ACS requested full claim refund – wrong provider paid
8062	HCE/SUR requested full claim refund – wrong recipient number
8063	HCE/SUR requested full claim refund – wrong drug/procedure/modifier
8064	HCE/SUR requested full claim refund – wrong units of service
8065	HCE/SUR requested full claim refund – TPL (other health insurance) related
8066	HCE/SUR requested full claim refund – TPL Medicare-related
8067	HCE/SUR requested full claim refund – wrong service date(s)
8068	EDS requested a full refund due to wrong patient liability amount
8069	HCE/SUR requested a full refund date due to wrong charge billed
8070 -8078	**Reserved for future use**
8079	EDS requested full claim refund – misc. or unspecified
8160	Provider initiated overpayment refund adjustment – duplicate payment
8161	Provider initiated overpayment refund adjustment – wrong drug/procedure/modifier
8162	Provider initiated overpayment refund adjustment – wrong units of service
8163	Provider initiated overpayment refund adjustment – wrong patient liability amount
8164	Provider initiated overpayment refund adjustment – TPL (other health insurance) related
8165	Provider initiated overpayment refund adjustment – TPL Medicare-related
8166	Provider initiated overpayment refund adjustment – wrong service date(s)
8167	Provider initiated overpayment refund adjustment – wrong submitted charge
8168-8178	**Reserved for future use**

(Continued)

Table F.1 – Cash Disposition Reason Codes

Code	Description
8179	Provider initiated overpayment refund adjustment – misc. or unspecified
8180	SUR requested overpayment refund adjustment – duplicate payment
8181	SUR requested overpayment refund adjustment – wrong drug/procedure/modifier
8182	SUR requested overpayment refund adjustment – wrong units of service
8183	SUR requested overpayment refund adjustment – wrong patient liability amount
8184	SUR requested overpayment refund adjustment – TPL (other health insurance) related
8185	SUR requested overpayment refund adjustment – TPL Medicare-related
8186	SUR requested overpayment refund adjustment – wrong service date(s)
8187-8198	**Reserved for future use**
8199	SUR requested overpayment refund adjustment – misc. or unspecified
8220	Nonclaim-specific Refund – TPL (other health Insurance related)
8221	Nonclaim-specific Refund – TPL (Medicare-related)
8222	Nonclaim-specific Refund – TPL (special projects)
8223	Nonclaim-specific Refund – SUR
8225-8228	**Reserved for future use**
8229	Nonclaim-specific Refund – Misc.
8302	Provider payout – over refund (sys)
8303	Provider payout – over refund (man)
8436	A/R decrease – cash receipt applied to principal
8437	A/R decrease – provider over-refund applied
8441	A/R decrease – cash receipt applied to interest
8512	Decrease to original lien amount – payment received

Appendix G: Claim Types

Table G.1 – Claim Types

Code	Description
A	UB-92 Inst
B	CMS-1500
C	UB-92 Outp
D	Dental
E	Encounter
H	Home Health
M	Medical
I	Inpatient
L	Long-term Care
O	Outpatient
P	Pharmacy

Appendix H: County Codes

Table H.1 – County Codes

Code	County	Code	County	Code	County
01	Adams	33	Henry	65	Posey
02	Allen	34	Howard	66	Pulaski
03	Bartholomew	35	Huntington	67	Putnam
04	Benton	36	Jackson	68	Randolph
05	Blackford	37	Jasper	69	Ripley
06	Boone	38	Jay	70	Rush
07	Brown	39	Jefferson	71	Scott
08	Carroll	40	Jennings	72	Shelby
09	Cass	41	Johnson	73	Spencer
10	Clark	42	Knox	74	Starke
11	Clay	43	Kosciusko	75	Steuben
12	Clinton	44	Lagrange	76	St. Joseph
13	Crawford	45	Lake	77	Sullivan
14	Davies	46	Laporte	78	Switzerland
15	Dearborn	47	Lawrence	79	Tippecanoe
16	Decatur	48	Madison	80	Tipton
17	Dekalb	49	Marion	81	Union
18	Delaware	50	Marshall	82	Vanderburgh
19	Dubois	51	Martin	83	Vermillion
20	Elkhart	52	Miami	84	Vigo
21	Fayette	53	Monroe	85	Wabash
22	Floyd	54	Montgomery	86	Warren
23	Fountain	55	Morgan	87	Warrick
24	Franklin	56	Newton	88	Washington
25	Fulton	57	Noble	89	Wayne
26	Gibson	58	Ohio	90	Wells
27	Grant	59	Orange	91	White
28	Greene	60	Owen	92	Whitley
29	Hamilton	61	Parke	94	IFSSA
30	Hancock	62	Perry	99	Out-of-State
31	Harrison	63	Pike		
32	Hendricks	64	Porter		

Appendix I: Claim Batch Ranges

Table I.1 – Claim Batch Ranges

Claim Type	Batch Range
Crossover	
UB-92 Inst A	000-015
CMS-1500 B	016-049
UB-92 Outpt C	000-015
Dental (ADA)	050-099
Inpatient (UB-92)	100-129
Outpatient (UB-92)	130-149
Long-term Care (UB-92)	150-249
Home Health (UB-92)	250-299
Pharmacy (Drug)	300-599
CMS-1500	600-899

Appendix J: Region Codes

Table J.1 – Region Codes

Region	Description
10	Paper
11	Paper with Attachments
12	CCF
20	Electronic
21	Electronic with Attachments
22	Shadow (Encounter)
23	Electronic Crossover Claims using PES
25	Point of Service
26	Point of Service with Attachments
33	To be Defined
40	Claims Converted from Old MMIS
41	590 Claims Converted from Old MMIS
45	Adjustments Converted from Old MMIS
46	590 Adjustments Converted from Old MMIS
47	Converted Credits
48	Converted Voids
49	Recipient Linking Claims
50	Adjustment – Noncheck-Related
51	Adjustment – Check-related
52	Shadow Claim Adjustments
53	Shadow Claim Adjustments
54	Mass Adjustments – Void Transaction
55	Mass Adjustments – Institutional Retro Rate
56	Mass Adjustments – System Generated
57	Mass Adjustments – Reprocessed by EDS System Engineers
58	Claims Processed by EDS System Engineers
59	POS Reversal Adjustment
60	Nonclaim-Specific Financial Transactions
70	HMO Capitation
80	Claims Reprocessed by EDS Systems Engineers
90	Special Projects
99	Converted Claim with duplicate ICN

Appendix K: Expenditure Setup Reason Codes

Table K.1 – Expenditure Setup Reason Codes

Code	Description
8300	Provider payout – system generated
8301	Provider payout – manual check
8302	Provider payout – over refund (sys)
8303	Provider payout – over refund (man)
8304	Provider payout – advance (sys)
8305	Provider payout – partial payment (man)
8306	**Reserved for future use**
8307	Provider Payout – manual check (balance of stop paid check applied to A/R)
8319	**Reserved for future use**
8320	Other entity payout – outside Indiana*AIM*
8321-8399	**Reserved for future use**

Appendix L: Expenditure Payee Types

Table L.1 – Expenditure
Payee Types

Type	Description
C	TPL Carrier
O	Other
P	Provider
R	Recipient
Y	County

Appendix M: Lien Disposition Reason Codes

Table M.1 – Lien Disposition Reason Codes

Code	Description
8510	Cycle Activity
8511	Decrease to original lien amount received by lien holder
8512	Decrease to original lien amount – payment received
8513	Increase to original lien amount received by lien holder
8514	Release of lien received by lien holder
8515-8599	**Reserved for future use**

Appendix N: Medical Assistance Program Codes

Table N.1 – Medical Assistance Programs

Code	Program
MA	Medicaid Program
59	590 Program
CS	Children's Special Health Care Services
MR	Disability Determination
AR	Assistance to Residents in County Homes
K2	CHIP

Appendix O: Nonclaim Provider Refund Reason Codes

Table O.1 – Nonclaim Provider Refund Reason Codes

Code	Description
8220	Nonclaim-specific Refund – TPL (other health Insurance) related
8221	Nonclaim-specific Refund – TPL (Medicare-related)
8222	Nonclaim-specific Refund – TPL (special projects)
8223	Nonclaim-specific Refund – SUR
8225	**Reserved for future use**
8226	**Reserved for future use**
8227	**Reserved for future use**
8228	**Reserved for future use**
8229	Nonclaim-specific Refund – Misc.

Appendix P: Provider Types

Table P.1 – Provider Types

Provider Type		Provider Specialty	
01	Hospital	010	Acute Care Hospital
		011	Psychiatric Hospital
		012	Rehabilitation Hospital
02	Ambulatory Surgical Center	020	Ambulatory Surgical Center
03	Extended Care Facilities	030	Nursing Facilities
		031	ICF/MR
		032	Pediatric Nursing Facility
		033	Residential Care Facility
04	Rehabilitation Facility	040	Rehabilitation Facility
05	Home Health Agency	050	Home Health Agency
06	Hospice	060	Hospice
07	Capitation Provider	070	Risk Based managed Care (RBMC)
		071	Managed Care Org. (MCO)
		072	Prepaid Health Plan (PHP)
		073	Competitive Medical Plans (CMP)
08	Clinic	080	FQHC
		081	Rural Health Clinic (RHC)
		082	Medical Clinic
		083	Family Planning Clinic
		084	Nurse Practitioner Clinic
		085	Title V Clinic
		086	Dental Clinic
		087	Therapy Clinic
09	Advance Practice Nurse	090	Pediatric Nurse Practitioner
		091	Obstetric Nurse Practitioner
		092	Family Nurse Practitioner
		093	Nurse Practitioner (other)
		094	CRNA
		095	Certified Nurse Midwife
10	Mid-level Practitioner	100	Physician Assistant
		101	Anesthesiology Assistant

(Continued)

Table P.1 – Provider Types

Provider Type		Provider Specialty	
11	Mental Health Provider	110	Outpatient Mental Health Clinic
		111	Community Mental Health Center
		112	Psychologist
		113	Certified Psychologist
		114	Health Service Prov in Psych (HSPP)
		115	Certified Clinical Social Worker (MSW)
		116	Certified Social Worker
		117	Psychiatric Nurse
12	School Corporation	120	School Corporation
13	Public Health Agency	130	County Health Department
14	Podiatrist	140	Podiatrist
15	Chiropractor	150	Chiropractor
16	Nurse	160	Registered Nurse (RN)
		161	Licensed Practical Nurse (LPN)
		162	Registered Nurse Clinical (RNC)
17	Therapist	170	Physical Therapist
		171	Occupational Therapist
		172	Respiratory Therapist
		173	Speech-Hearing Therapist
18	Optometrist	180	Optometrist
19	Optician	190	Optician
20	Audiologist	200	Audiologist
21	Case Manager (Targeted)	210	Care Coordinator for Pregnant Women
		211	HIV Case Manager
		212	CSHCN Care Coordinator
22	Hearing Aid Dealer	220	Hearing Aid Dealer
23	Dietitian	230	Registered Dietitian
24	Pharmacy	240	Pharmacist
25	DME/Medical Supply Dealer	250	DME/Medical Supply Dealer
26	Transportation Provider	260	Ambulance
		261	Air Ambulance
		262	Bus

(Continued)

Table P.1 – Provider Types

Provider Type		Provider Specialty	
		263	Taxi
		264	Common Carrier (Ambulatory)
		265	Common Carrier (NonAmbulatory)
		266	Family Member
27	Dentist	270	Endodontist
		271	General Dentistry Practitioner
		272	Oral Surgeon
		273	Orthodontist
		274	Pediatric Dentist
		275	Periodontist
		276	Pedodontist
		277	Prosthesis
28	Laboratory	280	Independent Lab
		281	Mobile lab
29	X-Ray Clinic	290	Freestanding X-Ray Clinic
		291	Mobile X-Ray Clinic
30	End Stage Renal Disease (ESRD) Clinic	300	Freestanding Renal Dialysis Clinic
31	Physician	310	Allergist
		311	Anesthesiologist
		312	Cardiologist
		313	Cardiovascular Surgeon
		314	Dermatologist
		315	Emergency Medicine Practitioner
		316	Family Practitioner
		317	Gastroenterologist
		318	General Practitioner
		319	General Surgeon
		320	Geriatric Practitioner
		321	Hand Surgeon
		322	Internist
		323	Neonatologist
		324	Nephrologist

(Continued)

Table P.1 – Provider Types

Provider Type		Provider Specialty	
		325	Neurological Surgeon
		326	Neurologist
		327	Nuclear Medicine Practitioner
		328	OB/GYN
		329	Oncologist
		330	Ophthalmologist
		331	Orthopedic Surgeon
		332	Otologist, Laryngologist, Rhinologist
		333	Pathologist
		334	Pediatric Surgeon
		335	Pediatrician
		336	Physical Medicine & Rehab Practitioner
		337	Plastic Surgeon
		338	Proctologist
		339	Psychiatrist
		340	Pulmonary Disease Specialist
		341	Radiologist
		342	Thoracic Surgeon
		343	Urologist
		344	General Internist
		345	General Pediatrician
32	Waiver Provider	350	Aged Disabled Waiver
		351	Autistic Waiver
		352	Developmentally Disabled Waiver
		353	Home Care Based Services Waiver
		354	Medically Fragile Waiver
33	Non-Billing Waiver Case Manager	355	Non-Billing Case Manager
		356	Waiver - Traumatic Brain Injury
		357	Waiver - Assisted Living
		358	Waiver - Adult Foster Care
		359	Waiver - DD
		360	Waiver - Support Services

Appendix Q: Return to Sender Reason Codes

Table Q.1 – Return to Sender Reason Codes

Code	Description
R02	Does Not Belong to Medical Assistance Program
R03	No Documentation
R04	Check Not Filled Out Completely
R05	Further Endorsement by Another Party is Required
R20	Adjustment Past Filing Limit
R21	Invalid/Missing RID No.
R22	Detail Info. Missing/Invalid
R23	Spenddown Deductible Form (8A) Missing
R24	Adjustment Submitted for Denied Claim
R25	Claim Paid Appropriately
R99	Misc./Unspecified

Appendix R: Cash Control Number Batch Ranges

Table R.1 – Cash Control Number Batch Ranges

Batch Number	Cash Receipt Type
900-904	Attorney/Casualty
905-909	Provider Refund – TPL
910-914	Provider Refund – Non-TPL
915-919	Insurance Refund
920-921	590 Program Refunds
922-923	CSHCS Program Refunds
924-925	ARCH Program Refunds
930	System Check P. O. Returns
934	System Check – Provider Returns
939	System Check Voids
940-949	Credit Balance Projects
950	SUR Refunds
955	Medicaid Fraud
960-964	Drug Rebate – Manufacture Payments
965-969	Drug Rebate – Provider Refunds
997	RTS – Follow-up Required
998	RTS
999	Nonspecific

Glossary

1115(a) Section of the Social Security Act that allows states to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid program. Radical, system-wide changes are possible under this provision. Waivers must be approved by CMS. See also *Centers for Medicare & Medicaid Services, PACE, Waiver*.

11971 State form 11971; see *8A.*

1261A Division of Family and Children State Form 1261A, *Certification - Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility.*

1500 This is a claim form used by participating Medicaid providers to bill medical and medically related services.

1902(a)(1) Section of the Social Security Act that requires state Medicaid programs be in effect "in all political subdivisions of the state". See also *Statewideness.*

1902(a)(10) Section of the Social Security Act that requires state Medicaid programs provide services to people that are comparable in amount, duration and scope. See also *Comparability; Sections 1915(a), (b), and (c); Waiver*.

1902(a)(23) Section of the Social Security Act that requires state Medicaid programs ensure clients have the freedom to choose any qualified provider to deliver a covered service. See also *Freedom of Choice, Section 1915(b), Waiver.*

1902(r)(2) Section of the Social Security Act that allows states to use more liberal income and resource methodologies than those used to determine Supplemental Security Income (SSI) eligibility for determining Medicaid eligibility.

1903(m) Section of the Social Security Act that allows state Medicaid programs to develop risk contracts with health maintenance organizations or comparable entities. See also *Risk Contracts*.

1915(b) Section of the Social Security Act that allows states to waive Freedom of Choice. States may require that beneficiaries enroll in HMOs or other managed care programs, or select a physician to serve as their primary care case manager. Waivers must be approved by CMS.

1915(c) Section of the Social Security Act that allows states to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify to receive services in an ICF-MR, nursing facility or Institution for Mental Disease, or inpatient hospital. Waivers must be approved by CMS. See also *CLASS, HCS, MDCP, CMS, NF, Waiver.*

1915(c)(7)(b) Section of the Social Security Act that allows states to waive Medicaid requirements to establish alternative, community-based services for individuals with developmental disabilities who are placed in nursing facilities but require specialized services. Waivers must be approved by CMS. See also *CMS, HCS-O, Waiver*.

1929	Section of the Social Security Act that allows states to provide a broad range of home and community care to functionally disabled individuals as an optional state plan benefit. The option can serve only people over 65. In Indiana, individuals of any age may qualify to receive personal care services through Section 1929 if they meet the state's functional disability test and financial eligibility criteria. See also *Home and Community Care*.
450A	Social Evaluation for Long Term Care Admission.
450B	Certification by Physician for Long Term Care Services.
590 Program	A program for institutionalized persons under the jurisdiction of the Division of Mental Health, and Department of Health.
7748	State Form 7748, Medicaid Financial Report.
8A	DPW Form 8A State Form 11971, *Notice to Provider of Recipient Deductible.* Used to relay recipient spenddown information to providers.
AAA	Area Agency on Aging. This agency is a significant element in Home and Community-Based Services Waiver Programs.
AAP	American Academy of Pediatrics.
ABA	American Banking Association.
access	Term used to describe the action of entering and utilizing a computer application.
accommodation charge	A charge used only in institutional claims for bed, board, and nursing care.
accretion	An addition to a file or list. For example: the monthly additions to the Medicare Buy-In List.
ACSW	Academy of Certified Social Worker.
ADA	American Dental Association.
ADC	Adult Day Care.
adjudicate (claim, credit, adjustment)	To process a claim to pay or deny.
adjustment	(1) A transaction that adjusts and reprocesses a previously processed claim; (2) the contractor adjusts a provider's account by debiting underpayments or crediting overpayments on claims.
adjustment recoupments	Recoupments set up by the adjustments staff on recoup and reprocess transactions. A record of these recoupments is maintained by the Cash Control System until zero balanced.

Advance Planning Document (APD)	A planning guide the federal government requires when a state is requesting 90 percent funding for the design, development, and implementation of an MMIS.
AFDC	Aid to Families with Dependent Children (AFDC) is replaced with Temporary Assistance for Needy Families (TANF).
AG	Attorney General.
Aged and Medicare-Related Coverage Group	Needy individuals who have been designated by Department of Human Services (DHS) as medical assistance recipients, who are 65 years old or older, or recipients under any other category who are entitled to benefits under Medicare.
aid category	A designation within the State Social Services Department under which a person may be eligible for public assistance and/or medical assistance.
Aid to Families with Dependent Children (AFDC)	Needy families with dependent children eligible for benefits under the Medicaid Program, Title IV-A, Social Security Act.
Aid to the Blind (AB)	A classification or category of recipients eligible for benefits under the Medicaid Program.
AIM	Advanced Information Management.
allowed amount	Either the amount billed by a provider for a medical service, the Department's established fee, or the reasonable charge, whichever is the lesser figure.
alpha	A field of only alphabetical letters.
alphanumeric	A field of numbers and letters.
ambulance service supplier	A person, firm or institution approved for and participating in Medicare as an air, ground, or host ambulance service supplier or provider.
amount, duration, and scope	How an IHCP benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state Medicaid plans vary in what is actually covered.
ancillary charge	A charge, used only in institutional claims, for any item except accommodation fees. Examples include drug, laboratory and x-ray charges.
APS	Adult Protective Services.
ARCH	Aid to Residents in County Homes. A State-funded program that provides medical services to certain residents of county nursing homes.
Area Agency on Aging	Also known as AAA. This agency is a significant element in Home and Community-Based Services Waiver Programs.

Area Prevailing Charge	Under Medicare Part B, the charge level that on the basis of statistical data would cover the customary charges made for similar services in the same locality.
ASC	Ambulatory Surgery Center.
AT	Action Team.
auto assignment	Indiana*AIM* process that automatically assigns a managed care recipient to a managed care provider if the recipient does not select a provider within a specified time frame.
Automated Voice Response (AVR)	Computerized voice response system that helps providers obtain pertinent information concerning recipient eligibility, benefit limitation, check information, and prior authorization (PA) for those participating in the IHCP.
Average Wholesale Price; used in reference to drug pricing.	Indiana*AIM* process that automatically assigns a managed care recipient to a managed care provider if the recipient does not select a provider within a specified time frame.
AVR	Automated voice-response system used by providers to obtain pertinent information concerning recipient eligibility, benefit limitation, check information, and PA for IHCP participants.
AWP	Average wholesale price used for drug pricing.
banner page	Brief messages sent to providers with the weekly remittance advices (RAs).
behavorial health care	Assessment and treatment of mental and/or psychoactive substance abuse disorders.
BENDEX	Beneficiary Data Exchange. A file containing data from CMS regarding persons receiving Medicaid benefits from the Social Security Administration.
Beneficiary	One who benefits from program such as the IHCP. Most commonly used to refer to people enrolled in the Medicare program.
benefit	A schedule of health care service coverage that an eligible participant in the IHCP receives for the treatment of illness, injury, or other conditions allowed by the State.
benefit level	Limit or degree of services a person is entitled to receive based on his or her contract with a health plan or insurer.
bidder	Any corporation, company, organization, or individual that responds to a Request for Proposal (RFP).
bill	Refers to a bill for medical services, the submitted claim document, or the electronic media claims (EMC) record. A bill may request payment for one or more performed services.

billed amount	The amount of money requested for payment by a provider for a particular service rendered.
billing provider	The party responsible for submitting to the department the bills for services rendered to an IHCP recipient.
billing service	An entity under contract with a provider who prepares billings on behalf of the provider for submission to payers.
block	Specific area on a claim or worksheet containing claim information.
Blue Book	The *American Druggist Blue Book*, used as a reference in pricing drug products.
Boren Amendment	An amendment to *OBRA 80 (P.O. 96-499)*, which repealed the requirement that states follow Medicare principles in reimbursing hospitals, nursing facilities (NF) and intermediate care facility for the mentally retarded (ICF/MR) under the IHCP. The amendment substituted language that required states to develop payment rates that were "reasonable and adequate" to meet the costs of "efficiently and economically operated" providers. Boren was intended to give states new flexibility but it has increased successful lawsuits by providers and thus has contributed to the rising cost of Medicaid-funded institutional care.
budgeted amount	The planned expenditures for a given time period.
bulletins	Informational directives sent to providers of Medicaid services containing information on regulations, billing procedures, benefits, processing, or changes in existing benefits/procedures.
buy-in	A procedure whereby the State pays a monthly premium to the Social Security Administration on behalf of eligible IHCP recipients, enrolling them in Medicare Part A or Part B or both programs.
C&T	Certification and Transmittal, a document from the Indiana State Department of Health (ISDH) that certifies institutional providers.
C519	Authorization for Recipient Liability Deviation, generated by the Medicaid recipient's county caseworker. Applies only to nursing residents.
cap	A finite limit on the number of certain services for which the department will pay for a given recipient per calendar year.
capitation	A prospective payment method that pays the provider of service a uniform amount for each person served usually on a monthly basis. Capitation is used in managed care alternatives such as HMOs.
carrier	An organization processing Medicare claims on behalf of the federal government.
carve out	A decision to purchase separately a service that is typically a part of an indemnity (a HMO plan). (For example, the behavioral health benefit might be carved out to a specialized vendor to supply these services as stand-alone.)

case management	A process whereby covered persons with specific health care needs are identified and a plan which efficiently uses health care resources is formulated and implemented to achieve the optimum outcome in the most cost-effective manner.
case manager	An experienced professional (for example, nurse, doctor or social worker) who works with clients, providers, and insurers to coordinate all necessary services to provide the client with a plan of medically necessary and appropriate health care.
Cash Control Number (CCN)	Financial control number assigned to uniquely identify all refunds or repayments prior to their setup within the cash control system. The batch range within the CCN identifies the type of refund or repayment.
cash control system	Process whereby the case unit creates and maintains the records for accounts receivable, recoupments, and payouts.
categorically needy	All individuals receiving financial assistance under the State's approved plan under Titles I, IV-A, X, XIV, and XVI of the Social Security Act or who are in need under the State's standards for financial eligibility in such plan.
category code	A designation indicating the type of benefits for which an IHCP recipient is eligible.
category of service	A designation of the nature of the service rendered (for example, hospital outpatient, pharmacy, physician).
CCF	Claim correction form. A CCF is generated by Indiana*AIM* and sent to the provider who submitted the claim. The CCF requests the provider to correct selected information and return the CCF with the additional or corrected information.
CCN	Cash control number. A financial control number assigned to identify individual transactions.
CDFC	County Division of Family and Children.
CEO	Chief Executive Officer.
certification	A review by CMS of an operational MMIS in response to a state's request for 75 percent FFP, to ensure that all legal and operational requirements are met by the system; also, the ensuing certification resulting from a favorable review.
certification code	A code PCCM PMPs use to authorize PCCM recipients to seek services from speciality providers.
CFR	Code of Federal Regulations. Federal regulations that implement and define federal Medicaid law and regulations.
CHAMPUS	Civilian Health and Medical Plan for the Uniformed Services; health-care plan for the uniformed services outside the military health-care system, now know as TRICARE.
charge center	A provider accounting unit within an institution used to accumulate specific cost data related to medical and health services rendered (for example, laboratory tests, emergency room service, and so forth.).

Children's Special Health Care Services (CSHCS)	State program that provides assistance for children with chronic health problems who are not necessarily eligible for Medicaid.
CI	Continual improvement.
claim	A provider's request for reimbursement of IHCP-covered services. Claims are submitted to the State's claims processing contractor using standardized claim forms: CMS-1500, UB-92, ADA Dental Form, and State-approved pharmacy claim forms.
Claim Correction Form (CCF)	Automatically generated for certain claim errors and sent to providers with the weekly RA. Allows providers the opportunity to correct specified errors detected on the claim during the processing cycle.
claim transaction	Any one of the records processed through the Claims Processing Subsystem. Examples are: (1) Claims (2) Credits (3) Adjustments.
claim type	Three-digit numeric code that refers to the different billing forms used by the program.
claims history file	Computer file of all claims, including crossovers and all subsequent adjustments that have been adjudicated by the MMIS.
claims processing agency	Agency that performs the claims processing function for Medicaid claims. The agency may be a department of the single state agency responsible for Title XIX or a contractor of the agency, such as a fiscal agent.
clean claim	Claim that can be processed without obtaining additional information from the provider or from a third party.
CLIA	Clinical Laboratory Improvement Amendments. A federally mandated set of certification criteria and a data collection monitoring system designed to ensure the proper certification of clinical laboratories.
client	A person enrolled in the IHCP and thus eligible to receive services funded through the IHCP. See also *Recipient*.
CMHC	Community Mental Health Center.
CMS	Centers for Medicare & Medicaid Services. Effective August 2001, this is the new name of the federal agency in the Department of Health and Human Services that oversees the Medicaid and Medicare programs. It was formerly known as the Health Care Financing Administration or HCFA.
CMS-1500	CMS-approved standardized claim form used to bill professional services.
Co-insurance	The portion of Medicare-determined allowed charge that a Medicare recipient is required to pay for a covered medical service after his/her deductible has been met. The co-insurance or a percentage amount is paid by Medicaid if the recipient is eligible for Medicaid. See also *Cost Sharing*.

Commerce Clearing House Guide	A publication containing Medicaid and Medicare regulations.
Community Living Assistance and Support Services (CLASS)	A waiver of the Medicaid state plan granted under Section 1915© of the Social Security Act that allows Indiana to provide community-based services to people with development disabilities other than mental retardation as an alternative to ICF MR VIII institutional care. Administered by Department of Human Services (DHS). See also *ICF MR, 1915©, Waiver*.
Computer-Output Microfilm (COM)	The product of a device that converts computer data directly to formatted microfilm images bypassing the normal print of output on paper.
Concurrent care	Multiple services rendered to the same patient during the same time period.
Consent to sterilization	Form used by IHCP recipients certifying that they give "informed consent" for sterilization to be performed (it must be signed at least 30 days prior to sterilization).
Contract amendment	Any written alteration in the specifications, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It includes bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
Contractor, contractors, or the contractor	Refers to all successful bidders for the services defined in any contract.
Conversion factor	Number that when multiplied by a particular procedure code's relative value units would yield a substitute prevailing charge that could be used when an actual prevailing charge does not exist.
Co-payment or co-pay	A cost-sharing arrangement that requires a covered person to pay a specified charge for a specified service, such as $10 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. See also *Cost Sharing*.
Core contractor	Vendor that successfully bids *on Service Package #1: Claims Processing and Related Services*.
Core services	Refers to *Service Package #1: Claims Processing and Related Services.*
COS	Category of Service.
Cost settlement	Process by which claims payments to institutional providers are adjusted yearly to reflect actual costs incurred.

Cost sharing	The generic term that includes co-payments, coinsurance, and deductibles. Co-payments are flat fees, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a drug prescription. Coinsurance is a percentage share of medical bills (for example, 20 percent) that an insured person must pay out-of-pocket. Deductibles are specified caps on out-of-pocket spending that an individual or a family must incur before insurance begins to make payments.
County office	County offices of the Division of Family and Children. Offices responsible for determining eligibility for IHCP using the Indiana Client Eligibility System (ICES).
Covered service	Mandatory medical services required by CMS and optional medical services approved by the State. Enrolled providers are reimbursed for these services provided to eligible IHCP recipients.
CP	Clinical psychologist.
CPAS	Claims Processing Assessment System. An automated claims analysis tool used by the State for contractor quality control reviews.
CPS	Child Protective Services.
CPT Codes (Current Procedural Terminology)	Unique coding structure scheme of all medical procedures approved and published by the American Medical Association.
CPU	Central processing unit.
CQM	Continuous quality management.
Credit	A claim transaction that has the effect of reversing a previously processed claim transaction.
CRF/DD	Community Residential Facility for the Developmentally Disabled.
Crippled Children's Program	Title V of the Social Security Act allowing states to locate and provide health services to crippled children or children suffering from conditions leading to crippling. Former term for CSHCS.
CRNA	Certified registered nurse anesthetist.
Crossover claim	A claim for services, rendered to a patient eligible for benefits under both Medicaid and Medicare Programs, Titles XVIII and XIX, potentially liable for payment of qualified medical services. (Medicare benefits must be processed prior to Medicaid benefits).
CRT Terminal (Cathode-Ray Tube Terminal)	A type of input/output device that may be programmed for file access capabilities, data entry capabilities or both.

CSHCS	Children's Special Health Care Services. A state-funded program providing assistance to children with chronic health problems. CSHCS recipients do not have to be IHCP-eligible. If they are also eligible for IHCP, children can be enrolled in both programs.
CSR	Customer Service Request.
CSW	Clinical social worker.
Customer	Individuals or entities that receive services or interact with the contractor supporting the IHCP, including state staff, recipients, and IHCP providers (managed care PMPs, managed care organizations, and waiver providers).
Data element	A specific unit of information having a unique meaning.
DD	Developmentally disabled or developmental disabilities.
DDARS	Division of Disability, Aging, and Rehabilitative Services.
Deductible	Fixed amount that a Medicare recipient must pay for medical services before Medicare coverage begins. The deductible must be paid annually before Part B medical coverage begins; and it must be paid for each benefit period before Part A coverage begins.
DESI	Drug determined to be less than effective (LTE); not covered by the IHCP.
Designee	Duly authorized representative of a person holding a superior position.
Detail	Information on a claim that denotes a specific procedure or category of certain services and the total charge billed for the procedure(s) involved. Also used to describe lines within a screen segment; for example, those listed to describe periods of eligibility.
Development disability	Mental retardation of a related condition. A severe, chronic disability manifested during the developmental period that results in impaired intellectual functioning or deficiencies in essential skills. See also *Mental Retardation, Related Condition.*
DHHS	U.S. Department of Health and Human Services. DHHS is responsible for the administration of Medicaid at the federal level through the CMS.
DHS	Department of Health Services.
Diagnosis	The classification of a disease or condition. (1) The art of distinguishing one disease from another. (2) Determination of the nature of a cause of a disease. (3) A concise technical description of the cause, nature, or manifestations of a condition, situation, or problem. (4) A code for the above. See also *ICD-9-CM, DRG*.
Digit	Any symbol expresses an idea or information, such as letters, numbers, and punctuation.
Direct price	Price the pharmacist pays for a drug purchased from a drug manufacturer.

Disallow	To determine that a billed service(s) is not covered by the IHCP and will not be paid.
Disposition	Application of a cash refund to a previously finalized claim. Also used in processing claims to identify claim finalization—payment or denial.
DME	Durable medical equipment. Examples include wheelchairs, hospital beds, and other nondisposable, medically necessary equipment.
DMH	Division of Mental Health.
DOS	Date of service; the specific day services were rendered.
Down	Term used to describe the inactivity of the computer due to power shortages or equipment problems. Entries on a terminal are not accepted during down time.
DPOC	Data Processing Oversight Commission. Indiana agency providing oversight and review of all State data processing statutes, policies, and procedures.
DPW	Department of Public Welfare, the previous name of the Office of Medicaid Policy and Planning.
DPW Form 8A	See *8A*.
DRG	Diagnosis-related grouping. Used as the basis for reimbursement of inpatient hospital services.
Drug code	Code established to identify a particular drug covered by the State Medicaid Program.
Drug Efficacy Study Implementation (DESI)	Listed drugs considered to be less than effective by the U.S. Food and Drug Administration. See also *Notice of Opportunity for Hearing (NOOH).*
Drug formulary	List of drugs covered by a State Medicaid Program, which includes the drug code, description, strength and manufacturer.
DSH	Disproportionate share hospital. A category defined by the State identifying hospitals that serve a disproportionately higher number of indigent patients.
DSM	Diagnostic and Statistical Manual of Mental Disorders; a revision series is usually associated with the reference, as well.
DSS	Decision Support System. A data extraction tool used to evaluate Medicaid data, trends, and so forth, for the purpose of making programmatic decisions.
Dual eligible	A person enrolled in Medicare and Medicaid.
Duplicate claim	A claim that is either totally or partially a duplicate of services previously paid.
DUR	Drug Utilization Review. A federally mandated, Medicaid-specific prospective and retrospective drug utilization review system and all related services, equipment, and activities necessary to meet all applicable federal DUR requirements.

EAC	Estimated acquisition cost of drugs. Federal pricing requirements for drugs.
ECC	Electronic claims capture. Refers to the direct transmission of electronic claims over phones lines to Indiana*AIM*. ECC uses point-of-sale devices and PCs for eligibility verification, claims capture, application of Pro-DUR, prepayment editing, and response to and acceptance of claims submitted on-line. Also known as ECS and EMC.
ECF	Extended care facility; primarily seen as LTC, long-term care; also seen as NH or NF.
ECM	Electronic claims management. Claims submitted in electronic format rather than paper. See *ECC*, *EMC*.
ECS	Electronic claims submittal. Claims submitted in electronic format rather than paper. See ***ECC, EMC***.
EDI	Electronic data interchange.
EDP	Electronic data processing.
EFT	Electronic funds transfer. Paying providers for approved claims via electronic transfer of funds from the State directly to the provider's account.
Eligibility file	File containing individual records for all persons who are eligible or have been eligible for the IHCP.
Eligible providers	Person, organization, or institution approved by the Single State Agency as eligible for participation in the IHCP.
Eligible recipient	Person certified by the State as eligible for medical assistance in accordance with the State Plan(s) under Title XIX of the Social Security Act, Title V of the Refugee Education Assistance Act, or State law.
EMC	Electronic media claims. Claims submitted in electronic format rather than paper. See *ECC*, *ECS*.
EMS	Emergency medical service.
EOB	Explanation of benefits. An explanation of claim denial or reduced payment included on the provider's RA.
EOMB	Explanation of Medicare benefits. A form provided by Indiana*AIM* and sent to recipients. The EOMB details the payment or denial of claims submitted by providers for services provided to recipients.
EOP	Explanation of payment. Describes the reimbursement activity on the provider's RA.
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment program. Known as HealthWatch in Indiana, EPSDT is a program for Medicaid-eligible recipients under 21 years old, offering free preventive health care services, such as screenings, well-child visits, and immunizations. If medical problems are discovered, the recipient is referred for further treatment.

Error code	Code connected to a claim transaction indicating the nature of an error condition associated with that claim. An error code can become a rejection code if the error condition is such that the claim is rejected.
Errors	Claims that are suspended prior to adjudication. Several classifications of errors could exist; for example claims with data discrepancies or claims held up for investigation of possible third party liability. Claims placed on suspense for investigatory action can be excluded from classification as an error at the user's option during detail system design. See also *Rejected Claim*.
ESRD	End-stage renal disease.
EST	Eastern Standard Time, which is also Indianapolis local time.
EVS	Eligibility Verification System. System used by providers to verify recipient eligibility using a point-of-sale device, online PC access, or an AVR system.
Exclusions	Illnesses, injuries, or other conditions for which there are no benefits.
Exclusive Provider Organization (EPO)	Arrangement between a provider network and a health insurance carrier or self-insured employer that requires the beneficiary to use only designated providers or sacrifice reimbursement altogether. See also *Preferred Provider Organization.*
Explanation of benefits (EOB)	An explanation of claim denial or reduced payment included on the provider's RA.
Family Planning Service	Any medically approved diagnosis, treatment, counseling, drugs, supplies or devices prescribed or furnished by a physician to individuals of child-bearing age for purposes of enabling such individuals to determine the number and spacing of their children.
FAMIS	Family Assistance Management Information System.
Fee-For-Service Reimbursement	The traditional health care payment system, under which physicians and other providers receive a payment for each unit of service they provide. See also *Indemnity Insurance.*
FEIN	Federal employer identification number. A number assigned to businesses by the federal government.
FFP	Federal financial participation. The federal government reimburses the State for a portion of the Medicaid administrative costs and expenditures for covered medical services.
Field audit	A provider's facilities, procedures, records and books are reviewed for conformance to IHCP standards. A field audit may be conducted regularly, routinely, or on a special basis to investigate suspected misutilization.
FIPS	Federal information processing standards.
Fiscal month	Monthly time interval in a fiscal year.

Fiscal year	Twelve-month period between settlements of financial accounts.
Fiscal year – federal	October 1 – September 30.
Fiscal year – Indiana	July 1 – June 30.
Flat rate	Reimbursement methodology in which all providers delivering the same service are paid at the same rate. Also known as a Uniform Rate.
FMAP	Federal Medical Assistance Percentage. The percentage of federal dollars available to a state to provide Medicaid services. FMAP is calculated annually based on a formula designed to provide a higher federal matching rate to states with lower per capita income.
Form 1261A	Division of Family and Children State Form 1261A, *Certification – Plan of Care for Inpatient Psychiatric Hospital Services Determination of Medicaid Eligibility*.
FPL	Federal poverty level. Income guidelines established annually by the federal government. Public assistance programs usually define income limits in relation to FPL.
FQHC	Federally Qualified Health Center. A center receiving a grant under the Public Health Services Act or entity receiving funds through a contract with a grantee. These include community health centers, migrant health centers, and health care for the homeless. FQHC services are mandated Medicaid services and may include comprehensive primary and preventive services, health education, and mental health services.
Freedom of choice	A State must ensure that IHCP beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of Medicaid and special contract options.
Front end	First process of claim cycle designed to create claim records, perform edits, and produce inventory reports.
Front-end process	All claims system activity that occurs before auditing.
FSSA	Family and Social Services Administration. The Office of Medicaid Policy and Planning (OMPP) is a part of FSSA. FSSA is an umbrella agency responsible for administering most Indiana public assistance programs. However, the OMPP is designated as the single State agency responsible for administering the Indiana Medicaid program.
FUL	Federal upper limit, the pricing structure associated with maximum allowable cost (MAC) pricing.
Generic drug	A chemically equivalent copy designed from a brand name whose patent has expired and is typically less expensive.

Group Model Health Maintenance Organization	A health care model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.
Group practice	A medical practice in which several physicians render and bill for services under a single billing provider number.
Hard copy claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as “paper” and “manual”.
HBP	Hospital-Based Physician. A physician who performs services in a hospital setting and has a financial arrangement to receive income from that hospital for the services performed.
HCBS	Home- and Community-Based Services waiver programs. A federal category of Medicaid services, established by Section 2176 of the Social Security Act. HCBS includes: adult day care, respite care, homemaker services, training in activities of daily living skills, and other services that are not normally covered by Medicaid. Services are provided to disabled and aged recipients to allow them to live in the community and avoid being placed in an institution.
HCE	Health Care Excel.
HCFA	Health Care Financing Administration. This is the previous name of the federal agency in the Department of Health and Human Services that oversees the Medicaid and Medicare programs. Effective August 2001, it is called the Centers for Medicare & Medicaid Services.
HCI	Hospital Care for the Indigent. A program that pays for emergency hospital care for needy persons who are not covered under any other medical assistance program.
HCPCS	CMS Common Procedure Coding System. A uniform health care procedural coding system approved for use by CMS. HCPCS includes all subsequent editions and revisions.
Header	Identification and summary information at the head (top) of a claim form or report.
HealthWatch	Indiana’s preventive care program for Medicaid recipients under 21 years of age. Also known as EPSDT.
HEDIS	Health Plan Employer Data and Information Set. A core set of performance measures developed for employers to use in assessing health plans.
Help	An online computer function designed to assist users when encountering difficulties entering a screen.
HHA	Home Health Agency. An agency or organization approved as a home health agency under Medicare and designated by ISDH as a Title XIX home health agency.

HHPD	Hoosier Healthwise for Persons with Disabilities and Chronic Diseases, formerly referred to as MCPD. HHPD is one of three delivery systems in the Hoosier Healthwise managed care program. In HHPD, an MCO is reimbursed on a per capita basis per month to manage the member's health care. This delivery system serves people identified as disabled under the IHCP definition.
HHS	Health and Human Services. U.S. Department of Health and Human Services. Umbrella agency for the Office of Family Assistance, the CMS, the Office of Refugee Resettlement (ORR), and other federal agencies serving health and human service needs.
HIC #	Health Insurance Carrier Number. Identification number for those patients with Medicare coverage. The HIC# is usually the patient's Social Security number and an alphabetic suffix that denotes different types of benefits.
HIO	Health insuring organization.
HIPP	Health insurance premium payments.
HMO	Health maintenance organization. Organization that delivers and manages health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of what the typical patient will cost. If enrollees cost more, the HMO suffers losses. If the enrollees cost less, the HMO profits. This gives the HMO incentive to control costs. See also *Sections 1903(m) and 1915 (b), PHP, PPO, Primary Care Case Management.*
HMS	Health Management Services.
Home and Community Care for the Functionally Disabled	An optional state plan benefit that allows states to provide HCBS to functionally disabled individuals (In Indiana, this optional benefit is used by ISDH to provide personal care services to people who have income in excess of SSI limitations but who would be financially qualified in an institution.) Also known as the "Frail Elderly" provision, although Indiana can serve people of any age under this provision. See also *Section 1919, Primary Home Care.*
Home and Community-Based Services-Omnibus Budget Reconciliation Act (HCS-OBRA)	A waiver of the Medicaid state plan granted under Section *1915©(7)(b)* of the Social Security Act that allows Indiana to provide community-based services to certain people with developmental disabilities placed in nursing facilities but requiring specialized service according to the PASARR process. See also *Section 1915(c)(7)(b), PASARR, Waiver.*
Home Health Care Services	Visits ordered by a physician authorized by DHS and provided to homebound recipients by licensed registered and practical nurses and nurses aids from authorized home health care agencies. These services include medical supplies, appliances, and DME suitable for use in the home.
Hoosier Healthwise	IHCP managed-care program. Hoosier Healthwise has three components including Primary Care Case Management (PCCM), and Risk-Based Managed Care (RBMC).

HPB	Health Professions Bureau.
HRI	Health-related items.
IAC	Indiana Administrative Code. State government agency administrative procedures.
IC	Indiana code.
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification. ICD-9-CM codes are standardized diagnosis codes used on claims submitted by providers.
ICES	Indiana Client Eligibility System. Caseworkers in the county offices of the Division of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
ICF	Intermediate care facility. Institution providing health-related care and services to individuals who do not require the degree of care provided by a hospital or skilled nursing home, but who, because of their physical or mental condition, require services beyond the level of room and board.
ICF/MR	Intermediate care facility for the mentally retarded. An ICF/MR provides residential care treatment for Medicaid-eligible, mentally retarded individuals.
ICN	Internal control number. Number assigned to claims, attachments, or adjustments received in the fiscal agent contractor's mailroom.
ICU	Intensive care unit.
IDDARS	Indiana Division of Disability, Aging, and Rehabilitative Services.
IDEA	Individuals with Disabilities Education Act.
IDOA	Indiana Department of Administration. Conducts State financial operations including: purchasing, financial management, claims management, quality assurance, payroll for State staff, institutional finance, and general services such as leasing and human resources.
IEP	Individual Education Program (in relation to the First Steps Early Intervention System).
IFSP	Individual Family Service Plan (in relation to the First Steps Early Intervention System).
IFSSA	Indiana Family and Social Services Administration.
IMCA	Indiana Motor Carrier Authority.
IMD	Institutions for mental disease.
IMF	Indiana Medical Foundation. Non-profit organization contracted by the DHS for the daily review and correction of abstracts submitted by all IHCP hospitals in Indiana.

IMFCU	Indiana Medicaid Fraud Control Unit.
IMRP	Indiana Medical Review Program. Program administered by the IMF to insure the medical necessity of hospitalization and surgery.
Indemnity insurance	Insurance product in which beneficiaries are allowed total freedom to choose their health care providers. Those providers are reimbursed a set fee each time they deliver a service. See also *Fee-for-Service*.
Indiana*AIM*	Indiana Advanced Information Management system. The State's current Medicaid Management Information System (MMIS).
Inquiry	Type of online screen programmed to display rather than enter information. Used to research information about recipients, providers, claims adjustments and cash transactions.
Institution	An entity that provides medical care and services other than that of a professional person. A business other than a private doctor or a pharmacy.
Intensive care	Level of care rendered by the attending physician to a critically ill patient requiring additional time and study beyond regular medical care.
Interim	A billing that is only for a portion of the patient's continuous complete stay in an inpatient setting.
Intermediary	Private insurance organizations under contract with the government handling Medicare claims from hospitals, skilled nursing facilities, and home health agencies.
IOC	Inspection of care. A core contract function reviewing the care of residents in psychiatric hospitals and ICFs/MR. The review process serves as a mechanism to ensure the health and welfare of institutionalized residents.
IPA	Individual Practice Associate. Model HMO. A health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.
IPP	Individualized Program Plan.
IRS	Identical, related, or similar drugs, in relation to less than effective (LTE) drugs.
ISBOH	Indiana State Board of Health. Currently known as the Indiana State Department of Health (ISDH).
ISDH	Indiana State Department of Health. Previously known as Indiana State Board of Health.
ISETS	Indiana Support Enforcement Tracking System.
ISMA	Indiana State Medical Association.

Itemization of charges	A breakdown of services rendered that allows each service to be coded.
ITF	Integrated test facility. A copy of the production version of Indiana*AIM* used for testing any maintenance and modifications before implementing changes in the production system.
JCL	Job control language.
Julian Date	A method of identifying days of the year by assigning numbers from 1 to 365 (or 366 on leap years) instead of by month, week, and day. For example, January 10 has a Julian date of 10 and December 31 has a Julian date of 365. This date format is easier and quicker for computer processing.
LAN	Local area network.
LCL	Lower Control Limit (Pertaining to quality control charts).
Licensed practical nurse	LPN.
Limited license practitioner	LLP.
Line item	A single procedure rendered to a recipient. A claim is made up for one or more line items for the same recipient.
LLP	Limited license practitioner.
LOA	Leave of absence.
LOC	Level-of-care. Medical LOC review determinations are rendered by OMPP staff for purposes of determining nursing home reimbursement.
Location	Location of the claim in the processing cycle such as paid, suspended, or denied.
Lock-in	Restriction of a recipient to particular providers, determined as necessary by the State.
Lock-out	Restriction of providers, for a time period, from participating in a portion or all of the IHCP due to exceeding standards defined by the department.
LOS	Length of stay.
LPN	Licensed practical nurse.
LSL	Lower specification limit, pertains to quality control charts.
LTC	Long term care. Facilities that supply long-term residential care to recipients.
LTE	Less than effective drugs.

M/M	Medicare/Medicaid.
MAC	Maximum allowable charge for drugs as specified by the federal government.
Managed care	System where the overall care of a patient is overseen by a single provider or organization. Many state Medicaid programs include managed care components as a method of ensuring quality in a cost efficient manner. See also *Section 1915(b), HMO, PPO, Primary Case Management.*
Mandated or required services	Services a state is required to offer to categorically needy clients under a state Medicaid plan. (Medically needy clients may be offered a more restrictive service package.) Mandated services include the following: Hospital (IP & OP), lab/x-ray, nursing facility care (21 and over), home health care, family planning, physician, nurse midwives, dental (medical/surgical), rural health clinic, certain nurse practitioners, federally qualified health centers, renal dialysis services, HealthWatch/EPSDT (under age 21), medical transportation.
Manual claim	Claim for services submitted on a paper claim form rather than via electronic means; also seen as *paper* and *hard copy*.
MARS	Management and Administrative Reporting Subsystem. A federally mandated comprehensive reporting module of Indiana*AIM* that includes data and reports as specified by federal requirements.
MCCA	Medicare Catastrophic Coverage Act of 1988.
MCO	Managed Care Organization. Entity that provides or contracts for managed care. MCOs include entities such as HMOs and Prepaid Health Plans (PHPs). See also *HMO, Prepaid Health Plan*.
MDS	Minimum data set.
Medicaid	A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.
Medicaid certification	The determination of a recipient's entitlement to Medicaid benefits and notification of that eligibility to the agency responsible for Medicaid claims processing.
Medicaid Financial Report	State Form 7748, used for cost reporting.
Medicaid fiscal agent	Contractor that provides the full range of services supporting the business functions included in the core and non-core service packages.
Medicaid plan	See also *Medicaid State Plan, Single State Agency.*
Medicaid Select	Indiana's new managed care healthcare program for people who have Medicaid for the aged, blind, and disabled.
Medicaid State plan	See also *Single State Agency, Medicaid Plan.*

Medicaid-Medicare eligible	Recipient who is eligible for benefits under both Medicaid and Medicare. Recipients in this category are *bought-in* for Part B coverage of the Medicare Program by the Medicaid Program.
medical emergency	Defined by the American College of Emergency Physicians as a medical condition manifesting itself by symptoms of sufficient severity that the abscence of immediate medical attention could reasonable be expected to result in: (a) placing health in jeopardy; (b) serious impairment to bodily function; (c) serious dysfunction of any bodily organ or part; or (d) development or continuance of severe pain.
medical necessity	The evaluation of health care services to determine if they are: medically appropriate and necessary to meet basic health needs; consistent with the diagnosis or condition and rendered in a cost-effective manner; and consistent with national medical practice guidelines regarding type, frequency and duration of treatment.
medical policy	Portion of the claim processing system whereby claim information is compared to standards and policies set by the state for the IHCP.
medical policy contractor	Successful bidder on *Service Package #2: Medical Policy and Review Services.*
medical supplies	Supplies, appliances, and equipment.
medically needy	Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan, but are insufficient to meet their costs of health and medical services.
Medicare	The federal medical assistance program described in Title XVIII of the Social Security Act for people over the age of 65, for persons eligible for Social Security disability payments and for certain workers or their dependents who require kidney dialysis or transplantation.
Medicare crossover	Process allowing for payment of Medicare deductibles and/or co-insurance by the Medicaid program.
Medicare deductibles and co-insurance	All charges classified as deductibles and/or coinsurance under Medicare Part A and/or Part B for services authorized by Medicare Part A and/or Part B.
mental disease	Any condition classified as a neurosis, psychoneurosis, psychopathy, psychosis or personality disorder.
mental illness	A single severe mental disorder, excluding mental retardation, or a combination of severe mental disorders as defined in the latest edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.*
mental retardation	Significantly sub-average intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

menu	Online screen displaying a list of the available screens and codes needed to access the online system.
MEQC	Medicaid eligibility quality control.
MFCU	Medicaid Fraud Control Unit.
microfiche	Miniature copies of the RAs that can store approximately 200 pages of information on a plastic sheet about the size of an index card.
microfilm	Miniature copies of all claims received by Medicaid stored on film for permanent records-keeping and referral
misutilization	Any usage of the IHCP by any of its providers or recipients not in conformance with both state and federal regulations, including both abuse and defects in level and quality of care.
MLOS	Mean Length of Stay.
MMDDYY	Format for a date to be reflected as month, day, and year such as 091599.
MMIS	Medicaid Management Information System. Indiana's current MMIS is Indiana*AIM*.
MOC	Memoranda of Collaboration. For example, a Hoosier Healthwise document that provides a formal description of the terms of collaboration between a PMP and PHCSP, and serves as a tool for delineating responsibilities for referrals on a continuous basis. MOCs must be signed by both parties and are subject to OMPP approval.
module	A group of data processing and/or manual processes that work in conjunction with each other to accomplish a specific function.
MRN	Medicare remittance notice
MRO	Medicaid Rehabilitation Option. Special program restricted to community mental health centers for persons who are seriously mentally ill or seriously emotionally disturbed.
MRT	Medical Review Team. FSSA Unit that makes decisions regarding disability determination.
MSW	Master of Social Work.
NCPDP	National Council for Prescription Drug Programs.
NDC	National Drug Code. A generally accepted system for the identification of prescription and non-prescription drugs available in the United States. NDC includes all subsequent editions, revisions, additions, and periodic updates.
NEC	Not elsewhere classified.

NECS	National Electronic Claims Submission is the proprietary software developed by EDS. NECS is installed on a provider's PCs and used to submit claims electronically. The software allows providers access to online, real-time eligibility information.
Network Model HMO	An HMO type in which the HMO contracts with more than one physician group, and may contract with single- and multi-specialty groups. The physician works out of his or her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively for HMO members.
NF	Nursing facility.
NH	Nursing home.
NOC	Not otherwise classified.
non-core contractors	Refers to the Medical Policy Contractor and the TPL/Drug Rebate Contractor.
non-core services	Refers to *Service Packages #2 and #3*.
NOOH	Notice of Opportunity for Hearing. Notification that a drug product is the subject of a notice of opportunity for hearing issued under Section 505(e) of the Federal Food, Drug, and Cosmetic Act and published in the *Federal Register* on a proposed order of FDA to withdraw its approval for the drug product because it has determined that the product is less than effective for all its labeled indications.
NPIN	National provider identification number.
nursing facilities	Facilities licensed by and approved by the state in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) Long Term Care Program. See also *Long Term Care, TILE.*
nursing facility waiver (NF waiver)	A waiver of the Medicaid's state plan granted under Section 1915(c) of the Social Security Act that allows Indiana to provide community-based services to adults as an alternative to nursing facility care. See also *Nursing Facilities, 1915(c), Waiver*.
OASDI	Old Age, Survivors and Disability Insurance. See also *Title II Benefits (Social Security or OASDI).*
OB/GYN	Obstetrician/Gynecologist.
OBRA	Omnibus Budget Reconciliation Act. Federal laws that direct how federal monies are to be expended. Amendments to Medicaid eligibility and benefit rules are frequently made in such acts.
OCR	Optical Character Recognition Equipment. A device that reads letters or numbers from a page and converts them to computerized data, bypassing data entry.
OMNI	Point-of-sale device used by providers to scan recipient ID cards to determine eligibility.

OMPP	Office of Medicaid Policy and Planning.
optional services or benefits	More than 30 different services that a state can elect to cover under a state Medicaid plan. Examples include personal care, rehabilitative services, prescribed drugs, therapies, diagnostic services, ICF-MR, targeted case managed, and so forth.
OTC	Over the counter (in reference to drugs).
other insurance	Any health insurance benefits that a patient might possess in addition to Medicaid or Medicare.
other processing agency	Any organization or agency that performs Medicaid functions under the direction of the single state agency. The single state agency may perform all Medicaid functions itself or it may delegate certain functions to other processing agencies.
outcome measures	Assessments that gauge the effect or results of treatment for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity, and health status.
outcomes	Results achieved through a given health care service, prescription drug use, or medical procedure.
outcomes management	Systematically improving health care results, typically by modifying practices in response to data gleaned through outcomes measurement, then remeasuring and remodifying, often in a formal program of continuous quality improvement.
outcomes research	Studies aimed at measuring effect of a given product, procedure, or medical technology on health or costs.
outlier	An additional payment made to hospitals for certain clients under age 21 for exceptionally long or expensive hospital stays.
out-of-state	Billing for a Medicaid recipient from a facility or physician outside Indiana or from a military facility.
outpatient services	Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.
overpayment	An amount included in a payment to a provider for services provided to a Medicaid recipient resulting from the failure of the contractor to use available information or to process correctly.
override	Forced bypassing of a claim due to error (or suspected error), edit, or audit failure during claims processing. Exempted from payment pending subsequent investigation not to be in error.
overutilization	Use of health or medical services beyond what is considered normal.

PA	Prior authorization. Some designated Medicaid services require providers to request approval of certain types or amounts of services from the State before providing those services. The Medical Services Contractor and/or State medical consultants review PAs for medical necessity, reasonableness, and other criteria.
paid amount	Net amount of money allowed by Medicaid.
paid claim	Claim that has had some dollar amount paid to the provider, but the amount may be less than the amount billed by the provider.
paid claims history file	History of all claims received by Medicaid that have been handled by the computer processing system through a terminal point. Besides keeping history information on paid claims, this file also has records of claims that were denied.
paper claim	A claim for services that was submitted on a paper claim form rather than via electronic means; also seen as *hard copy* and *manual*.
paperless claims	Claims sent by electronic means; equivalent to EMC, ECS, ECC, and similar terms denoting claim transmittal via electronic media.
parameter	Factor that determines a range of variations.
Part A	Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and after a hospital stay, for inpatient care in a skilled nursing facility, for home care by a home health agency or hospice care by a licensed and certified hospice agency. See also *Medicare, Beneficiary*.
Part B	Medicare medical insurance that helps pay for medically necessary physician services, outpatient hospital services, outpatient physical therapy, and speech pathology services, and a number of other medical services and supplies that are not covered by the hospital insurance. Part B will pay for certain inpatient services if the beneficiary does not have Part A. See also *Medicare, SMIB, Buy-In*.
participant	One who participates in the IHCP as either a provider or a recipient of services.
participating providers	Providers who furnish Title XIX services during a specified period of time.
participating recipients	Individuals who receive Title XIX services during a specified period of time.
participation agreement	A contract between a provider of medical service and the state that specifies the conditions and the services the facility must provide to serve Medicaid recipients and receive reimbursement for those services.
PAS	Pre-admission screening. A nursing home and community-based services program implemented on January 1, 1987, that is designed to screen a recipient's potential for remaining in the community and receiving community-based services as an alternative to nursing home placement.
PASRR	Pre-Admission Screening and Resident Review. A set of federally required long-term-care resident screening and evaluation services, payable by the Medicaid program, and authorized by the Omnibus Budget and Reconciliation Act of 1987.

payouts	Generate payments to providers for monies owed to them that are not claim related. Payouts are done as the result of cost settlements or to return excess refunds to the provider.
PCA	Physician's Corporation of America. An HMO providing health benefits to Medicaid clients.
PCCM	Primary care case management. One of three delivery systems within the Hoosier Healthwise managed care program. Providers in PCCM are reimbursed on a fee-for-service basis. Recipients are assigned to a primary medical provider (PMP) or group that is responsible for managing the care of the recipient and providing all primary care and authorizing specialty care for the recipient—24 hours a day, seven days a week.
PCN	Primary care network.
PCP	Primary care physician. A physician the majority of whose practice is devoted to internal medicine, family/general practice, and pediatrics. An obstetrician/gynecologist may be considered a primary care physician.
PDD	Professional data dimensions.
PDR	Provider Detail Report/Provider Desk Review.
peer	A person or committee in the same profession as the provider whose claim is being reviewed.
peer review	An activity by a group or groups of practitioners or other providers, by which the practices of their peers are reviewed for conformance to generally-accepted standards.
pending (claim)	Action of postponing adjudication of a claim until a later processing cycle.
per diem	Daily rate charged by institutional providers.
performing provider	Party who actually performs the service/provides treatment.
PERS	Personal emergency response system, an electronic device that enables the consumer to secure help in an emergency.
personal care	Optional Medicaid benefit that allows a state to provide attendant services to assist functionally impaired individuals in performing the activities of daily living (for example, bathing, dressing, feeding, grooming). Indiana provides Primary Home Care Services under this option. See also *Primary Home Care*.
PGA	Peer group average.
PHC	Primary home care. Medicaid-funded community care that provides personal care services to over 40,000 aged or disabled people in Indiana. PHC is provided as an optional state plan benefit. See also *Personal Care*.
PHP	Prepaid health plan. A partially capitated managed care arrangement in which the managed care company is at risk for certain outpatient services. See also *VISTA*.

physician hospital organization	An organization whose board is composed of physicians, but with a hospital member, formed for the purpose of negotiating contracts with insurance carriers and self-insured employers for the provision of health care services to enrollees by the hospital and participating members of the hospital's medical staff.
plan of care	A formal plan developed to address the specific needs of an individual; links clients with needed services.
PM/PM	Per member per month. Unit of measure related to each member for each month the member was enrolled in a managed care plan. The calculation is as follows: # of units/member months (MM).
PMP	Primary medical provider. A physician who approves and manages the care and medical services provided to Medicaid recipients assigned to the PMP's care.
pool (risk pool)	A defined account (for example, defined by size, geographic location, claim dollars that exceed **x** level per individual, and so forth) to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities of a given defined account as well as required funding to support the claim liability.
POS	Place of service or point of sale, depending on the context.
PPO	Preferred provider organization. An arrangement between a provider network and a health insurance carrier or a self-insured employer. Providers generally accept payments less than traditional fee-for-service payments in return for a potentially greater share of the patient market. PPO enrollees are not required to use the preferred providers, but are given strong financial incentives to do so, such as reduced coinsurance and deductibles. Providers do not accept financial risk for the management of care. See also *Exclusive Provider Organization (EPO)*.
PR	Provider relations.
practitioner	An individual provider. One who practices a health or medical service profession.
pre-payment review	Provider claims suspended temporarily for dispositioning and manual review by the HCE SUR Unit.
prescription medication	Drug approved by the FDA that can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.
preventive care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well person care.
pricing	Determination of the IHCP allowable.
primary care	Basic or general health care traditionally provided by family practice, pediatrics, and internal medicine.
prime contractor	Contractor who contracts directly with the State for performance of the work specified.
print-out	Reports and information printed by the computer on data correlated in the computer's memory.

prior authorization	An authorization from the IHCP for the delivery of certain services. It must be obtained prior to the service for benefits to be provided within a certain time period, except in certain allowed instances. Examples of such services are abortions, goal-directed therapy, and EPSDT dental services.
private trust	Trust fund available to pay medical expenses.
PRO	Peer review organization.
procedure	Specific, singular medical service performed for the express purpose of identification or treatment of the patient's condition.
procedure code	A specific identification of a specific service using the appropriate series of coding systems such as the CDT, CPT, HCPCS, or ICD-9-CM.
processed claim	Claim where a determination of payment, nonpayment, or pending has been made. See also *Adjudicated Claim*.
Pro-DUR	Prospective Drug Utilization Review. The federally mandated, Medicaid-specific prospective drug utilization review system and all related services and activities needed to meet all federal Pro-DUR requirements and all DUR requirements.
profile	Total view of an individual provider's charges or a total view of services rendered to a recipient.
program director	Person at the contractor's local office who is responsible for overseeing the administration, management, and daily operation of the MMIS contract.
prosthetic devices	Devices that replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning body organ or limb.
provider	Person, group, agency, or other legal entity that provides a covered IHCP service to an IHCP recipient.
provider enrollment application	Required document for all providers who provide services to IHCP recipients.
provider manual	Primary source document for IHCP providers.
provider networks	Organizations of health care providers that service managed care plans. Network providers are selected with the expectation they deliver care inexpensively, and enrollees are channeled to network providers to control costs.
provider number	Unique individual or group number assigned to practitioners participating in the IHCP.
provider relations	Function or activity within that handles all relationships with providers of health care services.
provider type	Classification assigned to a provider such as hospital, doctor, dentist.
PSRO	Professional standards review organization.

purged	Claims are removed from history files according to specific criteria after 36 months from the claim's last financial date. Claims data is online for up to 36 months.
QA	Quality assurance.
QARI	Quality Assurance Reform Initiative. Guidelines established by the federal government for quality assurance in Medicaid managed care plans.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QDWI	Qualified disabled working individual. A federal category of Medicaid eligibility for disabled individuals whose incomes are less than 200 percent of the federal poverty level. Medicaid benefits cover payment of the Medicare Part A premium only.
QM	Quality management.
QMB	Qualified Medicare beneficiary. A federal category of Medicaid eligibility for aged, blind, or disabled individuals entitled to Medicare Part A whose incomes are less than 100 percent of the federal poverty level and assets less than twice the SSI asset limit. Medicaid benefits include payment of Medicare premiums, coinsurance, and deductibles only.
QMHP	Qualified mental health professional.
QMRP	Qualified mental retardation professional.
quality improvement	A continuous process that identifies problems in health care delivery, tests solutions to those problems, and constantly monitors the solutions for improvement.
QUCR	Quarterly Utilization Control Reports.
query	An inquiry for specific information not supplied on standardized reports.
RA	Remittance advice. A summary of payments produced by Indiana*AIM* explaining the provider reimbursement. RAs are sent to providers along with checks or EFT records.
RBA	Room and board assistance.
RBMC	Risk-based managed care. One of three delivery systems in the Hoosier Healthwise managed care program. In RBMC, a managed care organization is reimbursed on a per capita basis per month to manage the member's health care. The delivery system serves TANF recipients, pregnant women, and children.
RBRVS	Resource-based relative value scale. A reimbursement method used to calculate payment for physician, dentists, and other practitioners.
reasonable charge	Charge for health care services rendered that is consistent with efficiency, economy, and quality of the care provided, as determined by OMPP.

reasonable cost	All costs found necessary in the efficient delivery of needed health services. Reasonable cost is the normal payment method for Medicare Part A.
recidivism	The frequency of the same patient returning to a provider with the same presenting problems. Usually refers to inpatient hospital services.
recipient	A person who receives a IHCP service while eligible for the IHCP. People may be IHCP-eligible without being IHCP recipients. These individuals are called enrollees or members when in the Hoosier Healthwise Progam. See also *Client, Eligible Recipient.*
recipient relations	The activity within the single state agency that handles all relationships between the IHCP and individual recipients.
recipient restriction	A limitation or review status placed on a recipient that limits or controls access to the IHCP to a greater extent than for other nonrestricted recipients.
Red Book	Listing of the average wholesale drug prices.
referring provider	Provider who refers a recipient to another provider for treatment service.
regulation	Federal or state agency rule of general applicability designed and adopted to implement or interpret law, policy, or procedure.
reinsurance	Insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents. See also *Stop-Loss Insurance*.
rejected claim	Claim determined to be ineligible for payment to the provider, contains errors, such as claims for noncovered services, ineligible provider or patient, duplicate claims, or missing provider signature. Returned to the responsible provider for correction and resubmission prior to data entry into the system.
related condition	Disability other than mental retardation which manifests during the developmental period (before age 22) and results in substantial functional limitations in three of six major life activities (for example, self-care, expressive/receptive language, learning, mobility, self-direction, and capacity for independent living). These disabilities, which may include cerebral palsy, epilepsy, spina bifida, head injuries, and a host of other diagnoses, are said to be related to mental retardation in their effect upon the individual's functioning.
remittance advice (RA)	Comprehensive billing information concerning the recipient disposition of a provider's submitted IHCP claims.
Remittance and Status Report (R/A)	A computer report generated weekly to a provider to inform the provider about the status of finalized and pending claims. The R/A includes EOB codes that describe the reasons for claim cutbacks, and denials. The provider receives a check enclosed in the R/A when claims are paid.

rendering provider	A provider employed by a clinic or physician group that provides service as an employee. The employee is compensated by the group and therefore does not bill directly.
rep	Provider relations representative.
repayment receivables	Transaction established in the Cash Control System when a provider has received payment to which he was not entitled.
report item	Any unit of information or data appearing on an output report.
required field	Screen field that must be filled to display or update desired information.
resolution	Step taken to correct an action that caused a claim to suspend from the system.
resolutions	The area within the processing department responsible for edit and audit correction.
Retro-DUR	Restrospective Drug Utilization Review.
RFI	Request for Information.
RFP	Request for Proposals.
RHC	Rural health clinic.
RID	Recipient identification (ID) number; the unique number assigned to an individual who is eligible for Medical Assistance Programs services.
risk contract	An agreement with an MCO to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense or degree. See also *MCO, Pool, Risk Pool*.
RN	Registered nurse.
RNC	Registered nurse clinician.
route	Transfer of a claim to a certain area for special handling and review.
routine	A condition that can wait for a scheduled appointment
RPT	Registered physical therapist.
rural health clinic	Any agency or organization that is a rural health clinic certified and participating under Title XVIII of the Social Security Act and has been designated by DHS as a Title XIX rural health clinic.
RVS	Relative value study. A procedure coding structure for all medical procedures, based on the most common procedure used, that assigns relative value units to medical procedures according to the degree of difficulty.
SBOH	State Board of Health. Previous term for the State Department of Health.

screening	The use of quick, simple procedures carried out among large groups of people to sort out apparently well persons from those who have a disease or abnormality and to identify those in need of more definitive examination or treatment.
SD	Standard deviation.
SDA	Standard dollar amount.
SDX	State Data Exchange System. The Social Security Administration's method of transferring SSA entitlement information to the State.
selective contracting	Option under Section *1915(b)* of the Social Security Act that allows a state to develop a competitive contracting system for services such as inpatient hospital care.
SEPG	Software Engineering Process Group.
service date	Actual date on which a service(s) was rendered to a particular recipient by a particular provider.
service limits	Maximum number of service units to which a recipient is entitled, as established by the IHCP for a particular category of service. For example, the number of inpatient hospital days covered by the IHCP might be limited to no more than 30 days.
SG	Steering group.
shadow claims	Reports of individual patient encounters with an MCO's health care delivery system. Although MCOs are reimbursed on a per capita basis, these claims from MCOs contain fee-for-service equivalent detail regarding procedures, diagnoses, place of service, billed amounts, and the rendering or billing providers.
SIPOC	System map outlining suppliers, inputs, processes/functions, outputs, and customers.
SLMB	Specified low-income Medicare beneficiary. A federal category defining Medicaid eligibility for aged, blind, or disabled individuals with incomes between 100 percent and 120 percent of the federal poverty level and assets less than twice the SSI asset level. Medicaid benefits include payment of the Medicare Part B premium only.
SMI	Supplemental medical insurance, Part B of Medicare.
SNF	Skilled nursing facility.
SOBRA	Omnibus Budget Reconciliation Act of 1986.
SPC	Statistical process control.
special vendors	Provide support to IHCP business functions but the vendors are not currently Medicaid fiscal agents.
specialty	Specialized practice area of a provider.

specialty certification	Certification or approval by professional academy, association, or society that designates this provider has demonstrated a given level of training or competence and is a fellow or specialist.
specialty vendors	Provide support to IHCP business functions but the vendors are not currently IHCP fiscal agents.
spenddown	Process whereby Medicaid eligibility may be established if an individual's income is more than that allowed under the State's income standards and incurred medical expenses are at least equal to the difference between the income and the medically needy income standard.
SPMI	Severe and persistent mental illness.
SPR	System performance review.
SSA	Social Security Administration of the federal government.
SSCN	Social security claim number. Account number used by SSA to identify the individual on whose earnings SSA benefits are being paid. It is a social security account number followed by a suffix, sometimes as many as three characters, designating the type of beneficiary (for example, wife, widow, child, and so forth). The SSCN is the number that must be used in the Buy-In program. A beneficiary can have his own SSN but be receiving benefits under a different claim number.
SSI	Supplementary Security Income. A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.
SSN	Social Security Account Number. The number used by SSA throughout a wage earner's lifetime to identify his or her earnings under the Social Security Program. This account number consists of nine figures generally divided into three hyphenated sets, such as 000-00-0000. The account number is commonly known as the Social Security Number. The number is not to be confused with Social Security Claim Number.
SSP	State Supplement Program. State-funded program providing cash asssistance that supplements the income of those aged, blind, and disabled individuals who are receiving SSI (or who, except for income or certain other criteria, would be eligible for SSI).
SSRI	Selective Serotonin Re-uptake Inhibitor
Staff Model HMO	Health care model that employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.
standard business	Health care business within the private sector of the industry, such as Blue Cross and Blue Shield.
State	The state of Indiana and any of its departments, agencies, and public agencies.
State fiscal year	A 12-month period beginning July 1 and ending June 30.

State Medicaid Office Office of Medicaid Policy and Planning, within the Family and Social Services Administration, responsible for administering the Medicaid program in Indiana.

State Plan The medical assistance plan of Indiana as approved by the Secretary of Health, Education and Welfare in accordance with provisions of Title XIX of the Social Security Act, as amended.

status Condition of a claim at a given time; such as paid, pended, denied, and so forth.

stop-loss insurance Insurance coverage taken out by a health plan or self-funded employer to provide protection from losses resulting from claims greater than a specific dollar amount per covered person per year (calendar year or illness-to-illness). Types of stop-loss insurance: (1) Specific or individual-reimbursement is given for claims on any covered individual which exceed a predetermined deductible, such as $25,000 or $50,000; (2) Aggregate-reimbursement is given for claims which in total exceed a predetermined level, such as 125% of the amount expected in an average year. See also *Reinsurance*.

subcontractor Any person or firm undertaking a part of the work defined under the terms of a contract, by virtue of an agreement with the prime contractor. Before the subcontractor begins, the prime contractor must receive the written consent and approval of the State.

submission The act of a provider sending billings to EDS for payment.

subsystem A Medicaid term that refers to one of the following (I)HIS processing components: recipient's subsystem, provider subsystem, claims processing subsystem, reference file subsystem, surveillance and utilization review subsystem, and management and administrative reporting subsystem.

SUR Surveillance and Utilization Review. Refers to system functions and activities mandated by the CMS that are necessary to maintain complete and continuous compliance with CMS regulatory requirements for SUR including the following SPR requirements:

statistical analysis

exception processing

provider and recipient profiles

retrospective detection of claims processing edit/audit failures/errors

retrospective detection of payments and/or utilization inconsistent with State or federal program policies and/or medical necessity standards

retrospective detection of fraud and abuse by providers or recipients

sophisticated data and claim analysis including sampling and reporting

general access and processing features

general reports and output

suspended transaction A suspended transaction requires further action before it becomes a paid or denied transaction, usually because of the presence of error(s).

suspense file Computer file where various transactions are placed that cannot be processed completely, usually because of the presence of an error condition(s).

systems analyst/engineer	Responsible for performing the following activities: Detailed system/program design System/program development Maintenance and modification analysis/resolution User needs analysis User training support Development of personal Medicaid program knowledge
TANF	Temporary Assistance for Needy Families. A replacement program for Aid to Families with Dependent Children.
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982. The federal law which created the current risk and cost contract provisions under which health plans contract with CMS and which define the primary and secondary coverage responsibilities of the Medicare program.
TEFRA 134(a)	Provision of the Tax Equity and Fiscal Responsibility Act of 1982 that allows states to extend Medicaid coverage to certain disabled children.
therapeutic classification	Code assigned to a group of drugs that possess similar therapeutic qualities.
third party	An individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of an applicant for, or recipient of, medical assistance under Title XIX.
third-party resource	A resource available, other than from the department, to an eligible recipient for payment of medical bills. Includes, but is not limited to, health insurance, workmen's compensation, liability, and so forth.
Title I	The Old Age Assistance Program that was replaced by the Supplemental Security Income program (SSI).
Title II	Old Age, Survivors and Disability Insurance Benefits (Social Security or OASDI).
Title IV-A	AFDC, WIN Social Services.
Title IV-B	Child Welfare.
Title IV-D	Child Support.
Title IV-E	Foster Care and Adoption.
Title IV-F	Job Opportunities and Basic Skills Training.
Title V	Maternal and Child Health Services.
Title X	Aid to the Blind program (AB) replaced by the SSI.
Title XIV	Permanently and Totally Disabled program (PTD) replaced by the SSI.

Title XIX	Provisions of Title 42, United States code Annotated Section 1396-1396g, including any amendments thereto.
Title XIX Hospital	Hospital participating as a hospital under Medicare, that has in effect a utilization review plan (approved by DHS) applicable to all recipients to whom it renders services or supplies, and which has been designated by DHS as a Title XIX hospital; or a hospital not meeting all of the requirments of Subsection A.5.1.0.0.0 of the RFP but that renders services or supplies for which benefits are provided under Section 1814 (d) of Medicare or would have been provided under such section had the recipients to whom the services or supplies were rendered been eligible and enrolled under part A of Medicare, to the extent of such services and supplies only, and then only if such hospital has been approved by DHS to provide emergency hospital services and agrees that the reasonable cost of such services or supplies, as defined in Section 1901 (a) (13) of title XIX, shall be such hospital's total charge for such services and supplies.
Title XV	ISSI.
Title XVI	The SSI.
Title XVIII	The Medicare Health Insurance program covering hospitalization (Part A) and medical insurance (Part B); the provisions of Title 42, United States Code Annotated, Section 1395, including any amendments thereto.
TPL	Third Party Liability. A client's medical payment resources, other than Medicaid, available for paying medical claims. These resources generally consist of public and private insurance carriers.
TPL/Drug Rebate Services	Refers to *Service Package #3: Third-Party Liability and Drug Rebate Services.*
TQM	Total Quality Management.
trend	Measure of the rate at which the magnitude of a particular item of date is changing.
UB-92	Standard claim form used to bill hospital inpatient and outpatient, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), and hospice services.
UCC	Usual and customary charge.
UCL	Upper control limit, pertaining to quality control charts.
UCR	Usual, customary, and reasonable charge by providers to their most frequently billed nongovernmental third party payer.
unit of service	Measurement divisions for a particular service, such as one hour, one-quarter hour, an assessment, a day, and so forth.
UPC	Universal product code. Codes contained on the first data bank tape update and/or applied to products such as drugs and other pharmaceutical products.
UPIN	Universal provider identification number.
UR	Utilization review.

UR	Utilization Review. A formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.
urgent	Defined as a condition not likely to cause death or lasting harm, but for which treatment should not wait for the next day or a scheduled appointment.
user	Data processing system customer or client.
USL	Upper specification limits, pertaining to quality control charts.
utilization	The extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per numbers of persons eligible for the services.
utilization management	Process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.
VFC	Vaccines for Children program.
VFC	Vaccine for Children program.
VRS	Voice Response System, primarily seen as AVR, automated voice response system.
WAN	Wide area network.
WIC	Women, Infants, and Children program. A federal program administered by the Indiana Department of Health that provides nutritional supplements to low-income pregnant or breast-feeding women, and to infants and children under 5 years old.
workmen's compensation	A type of third-party liability for medical services rendered as the result of an on-the-job accident or injury to an individual for which his employer's insurance company may be obligated under the Workman's Compensation Act.

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